Primary Health Care Renewal
Action for Healthier Nova Scotians

Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal

Highlights

May, 2003

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WHAT IS PRIMARY HEALTH CARE?[1]

Primary health care is at the centre of a community-based health care system. It focuses on a person's health and well-being. It brings individuals, families, and health and community organizations together to take an active role in identifying and delivering health services in their communities.

It's not just about having enough doctors and nurses.

It's about providing care and contributing to well-being.

HIGHLIGHTS

It's about offering families faster and easier access to essential health services in their communities.

It's about offering services like health education and promotion, prevention, rehabilitation, and support and treatment for illness and injury.

It's about offering families faster and easier access to essential health services in their communities.

It's about looking at all the factors that influence and promote health. Factors like income, social support networks, education, employment, personal health practices, health services, gender, race, and culture. (These are also referred to as determinants of health.)

It's about offering the right blend of community-based services that will enable people to maintain and enhance their health.

BACKGROUND

The Nova Scotia Department of Health recognized that a strong primary health care system is the foundation needed to address the continuing health needs of Nova Scotians in their communities. In 2001, the Advisory Committee on Primary Health Care Renewal (committee) was established to help identify and recommend changes needed to further develop and sustain a community-based primary health care system.

The committee, composed of representatives from various health and community organizations and the department, has completed its report, *Primary Health Care Renewal: Action for Healthier Nova Scotians*, and has presented its findings and recommendations to the department.

This document highlights some of the findings and recommendations of the committee.

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[1] *Adapted from Nova Scotia Department of Health's Task Force on Primary Health Care, 1994, and Health Canada's Taking Action on Population Health, 1998.*

TODAY'S PRIMARY HEALTH CARE SYSTEM

The committee looked at the existing primary health care system to build on its successes in meeting the health needs of Nova Scotians in their communities.

Providing a Foundation

The existing primary health care system in Nova Scotia has many positive aspects that will provide the foundation for renewal efforts:

- The contribution of existing health care providers, including family doctors and public health providers, is recognized and highly valued by Nova Scotians.
- There are many instances where community and public organizations are coming together to plan and deliver health care services.
- Nova Scotia's community health boards participate in health planning and are actively involved in identifying community health needs.
- Nova Scotia has introduced nurse practitioners to communities as members of the health care team.
- An advanced information system is being developed to provide electronic patient records and a hospital information system.

Why Change?

The existing health care system does not yet meet the health care needs of *all* Nova Scotia communities.

By all stakeholders working together, there is an opportunity to improve the health and well-being of all Nova Scotians.

Health status of Nova Scotians

- Nova Scotia has higher than national average mortality rates related to cancer, respiratory disease, pneumonia and influenza, and circulatory disease.
- Nova Scotia has higher than national average rates of obesity, smoking, and physical inactivity. These are risk factors for chronic disease.
- Poor health status places enormous pressures on health systems. Primary health care incorporates efforts to prevent disease, not just treat it.
- There is a lack of information about the health status of Nova Scotia's minority populations. Such information is crucial to understanding the link between the determinants of health and health status.

The team approach to primary health care

- Primary health care teams, made up of a variety of professionals, are not yet well established in Nova Scotia. Many health care providers and community professionals can work together to meet the primary health care needs of individuals and communities.
- There are many examples of informal types of integration taking place in Nova Scotia's health care system today, but the primary health care system is still not well coordinated and integrated. This results, for example, in gaps in care, lack of coordination between levels of care, and redundancies and duplication in the care process.
- There is not enough collaboration among government departments, the private sector, and community organizations in primary health to ensure Nova Scotians are offered and have access to health services and activities close to home.
- The links made with community-based organizations are not often formally planned or supported.
- The current system relies heavily on family caregivers and volunteer organizations that are not well supported or integrated within the health care system.

Technology

- There is a lack of technology to support the sharing of information among health care providers and hospitals or other acute-care centres.
- There are no standard methods in place to measure the quality of health care across the province.
- Limited use of technology to provide information on quality and costs can result in the ineffective allocation of resources.

Communication

Individuals and families do not have enough information about health needs, the goals of primary health care, and the benefits and costs of services available to allow them to take an increased role in decisions about their wellness.

Access

- There is a need to ensure equality of access for all, especially for those who have faced barriers (poverty, ill health, gender, race, lack of education, disability, sexual orientation).
- Many people visit emergency departments for primary care if they have no family physician or if their physicians do not provide services at a time and place convenient for them. This unnecessarily burdens the emergency service, which is not intended to provide continuing personal health care.

Funding

The Department of Health does not specifically designate funds for primary health care. As compared to other Canadian provinces, Nova Scotia spends more in the areas of hospitals and physician services, and proportionately less in the areas of public health, administration, and capital expenditures.

NOVA SCOTIA'S VISION FOR PRIMARY HEALTH CARE

The committee, in consultation with 150 primary health care stakeholders, including policy and decision makers, front-line primary health care providers, and community representatives, developed a vision for primary health care in Nova Scotia. This vision has guided the work of the committee.

The vision states that

In 15 years the health status of Nova Scotians will be improved because individuals, families, communities, and non-government and government organizations within and outside the health sector have been enabled to positively influence the many factors that influence health.

(*Please see Appendix to view the vision in its entirety.*)

Under this vision, the new primary health care system will be

- community based, family focused, and person centred, with everyone in the community working together to define community health needs and the best ways to meet them
- comprehensive, offering many services and considering many factors that influence health when planning and delivering services
- responsive and flexible, offering support to communities to help identify changing needs and issues, and respond to those changing needs in a timely manner
- accessible, ensuring that Nova Scotians get equity of access to a defined range of primary health services in their communities
- integrated, collaborative, and innovative, linking with community health and cultural organizations

- accountable, making sure that the system receives ongoing evaluation related to its effectiveness and efficiency in meeting the needs of Nova Scotians
- sustainable, delivering quality activities to promote health and health care services that are efficient, affordable, and acceptable to the community

COMMITTEE RECOMMENDATIONS

While it is clear that change is necessary, the committee recommends an incremental approach that builds on the existing strengths and capacities of the existing primary health care system, and the voluntary participation of primary health care stakeholders.

Also recommended are criteria that can be used by communities, primary health care organizations, District Health Authorities (DHAs), and the Department of Health to ensure that their primary health care plans are consistent with the provincial vision for primary health care.

While not all primary health care services, programs, and organizations will be able to meet all of the criteria initially, the committee notes that they should strive to meet as many of the criteria as possible.

Services and Programs

To ensure that all Nova Scotians have access to a comprehensive range of health care services close to home, the committee recommends that the following services, over time, become the foundation of the primary health care system:

- basic emergency services
- communicable disease prevention and control
- community mental health services
- community supports
- continuing care (home care, long term care, small options homes, palliative care, etc.)
- dental health services
- environmental health services
- health promotion (including community development)
- healthy child development
- nutrition services
- primary maternity care
- prevention and treatment of common diseases and injuries
- rehabilitation services
- sexual health and family planning services
- other publicly funded services (services such as housing, income assistance, occupational health and safety, and education programs that are delivered by other government departments)

Contributors[2]

The roles of primary health care providers should change to include working as members of interdisciplinary collaborative teams, which would consist of core and extended team members.

Core providers would be those having longer-term and continuing relationships with clients, while extended providers would be those having shorter-term relationships with clients at times when they require specialized services.

The core team would include the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider(s), and midwife.

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[2] *The term "contributors" is used to name health care professionals and other persons whose work contributes to the health of individuals and communities. These include professionals (for example family physicians, nurse practitioners and public health providers), volunteers, family caregivers, neighbours, friends, and providers of alternative and complementary health care.*

Primary Maternity Care

The primary health care system should support a collaborative team-based approach to the delivery of primary maternity care with the participation of family physicians and midwives. This would require the creation of a regulatory and/or licensing structure for midwives in Nova Scotia.

Family Caregivers

Family caregivers should be involved in policy development and named in policies that affect them. Their needs should be assessed, and a range of supports (e.g. financial, emotional, information and education, and replacement care) should be available to them.

Complementary and Alternative Care

More work related to the possible relationship of complementary and alternative health care providers to the primary health care team should be conducted.

Integration and Linkages

- There should be planned linkages, networks, strategies, and functional integration among government departments, non-governmental organizations, communities, the academic sector, First Nations and other levels of care.
- Information and resources that contribute to individual and population health should be shared. As well, mechanisms to assist individuals and families in navigating through the health care system and the broad range of community supports and services should be developed.
- There should be a confidential and common electronic patient record for each Nova Scotian.

Governance

- Governance models should be used to lead Nova Scotia to achieve its vision for primary health care. These models would
    - demonstrate that community participation is real and it impacts decision making
    - give providers the opportunity to influence the direction of the organization
    - support collaboration and facilitate linkages among agencies within and external to the primary health care system, aligning with the primary health care goals and objectives of their respective DHA or the IWK Health Centre
    - ensure fiscal and clinical accountability, and the measurement of health outcomes
- Communities should develop governance solutions that adapt to local situations.

Accountability

- All Nova Scotians should share responsibility for their health and the health of communities and the accountabilities of all stakeholders should be clearly defined.
- There should be ongoing evaluation and support of informed evidence-based decision making with performance and outcomes standards.

Funding

Nova Scotia should move toward a population-based funding mechanism for primary health care in an evolutionary and incremental manner.

The objectives of population-based funding would be to

- improve access and continuity of health services

Population-based funding is a mechanism, or a mix of mechanisms, that attempts to match resource allocation to different levels of health status, health care needs, and services required to serve different populations.

- promote integration of health services
- enhance health promotion and illness prevention
- support the most appropriate health care provider, or team of providers, to provide primary health care services in the most appropriate settings
- provide incentives to improve quality, effectiveness and efficiency where evidence and/or best practice supports those improvements

Communities should work together to develop primary health care service delivery models that best reflect their assets and meet their needs. Participation in these models by providers and communities would be voluntary...

Models of Primary Health Care Service Delivery

Communities should work together to develop primary health care service delivery models that best reflect their assets and meet their needs. Participation in these models by providers and communities would be voluntary, allowing gradual movement toward models that reflect the broader primary health care approach.

Change Management

Given the complexity of primary health care renewal and the need to shift attitudes and behaviours of not only the public, but also providers and policy makers, multiple change management strategies should be developed.

The Department of Health and DHAs should also dedicate adequate funding and resources to support the change management strategies. Skilled transition and change managers would be recruited to champion the change process at the Department of Health and DHAs levels, and the Department of Health would work with the Office of Health Promotion on relevant activities.

Next Steps

While an incremental and voluntary approach to primary health care renewal will be key to its success, there are a number of activities that should take place in the immediate future so that primary health care renewal can begin:

The Department of Health should

- publicly endorse the direction recommended by the committee
- (with DHAs) commit support to community health boards (CHBs) so that they can fulfill their legislated mandate
- work with DHAs and the IWK Health Centre to undertake planned and thorough marketing and communication of the contents of *Primary Health Care Renewal: Action for Healthier Nova Scotians* to educate the public and other primary health care stakeholders about primary health care renewal in Nova Scotia

- work with DHAs and the IWK Health Centre to make information available so that all Nova Scotians understand the health issues and health status of their geographic, cultural, and ethnic communities
- lead and work with DHAs and the IWK Health Centre to develop time lines and implement the change management strategy identified in *Primary Health Care Renewal: Action for Healthier Nova Scotians*
- develop a strategy to overcome the jurisdictional issues that are barriers to the full participation of First Nations in the planning and delivery of primary health care
- work with DHAs, the Medical Society of Nova Scotia, and others to develop options for alternative funding arrangements for family physicians that supports the direction of primary health care renewal
- work with DHAs and the IWK Health Centre to develop a tool or mechanism to measure health outcomes and the impact of changes to primary health care.

APPENDIX

Appendix - Nova Scotia's Vision for Primary Health Care

In 15 years the health status of the population of Nova Scotia will be improved because individuals, families, communities and non-government and government organizations within and outside the health sector have been enabled to positively influence the many factors that influence health. Communities will be supported in their efforts to improve health by a primary health care system that is:

Community-based, family-focused, and person-centred.

This means that:

- Everyone in the community (individuals, families, primary health care providers, community groups, service delivery organizations and government) works together to identify and build upon community strengths and capacities, and to define community health needs and the best ways to meet them.
- The uniqueness and diversity of individuals, families and communities are valued and responded to appropriately.
- Individual, family and community capacities to improve health status and to participate in health services planning are increased.
- All Nova Scotians have an ongoing relationship with a primary health care provider through whom they can access health care services.

Comprehensive.

This means that:

- The many factors that influence health are considered in primary health care planning and delivery, including but not limited to income, social status, education, employment, healthy child development, genetic endowment, gender, culture, spirituality and race.
- The primary health care system provides a balance between activities that promote health and provide health care services.
- A wide range of services is offered by the primary health care system, including but not limited to primary care, continuing care (long term and home care), rehabilitative care, public health, emergency care, community mental health, addictions, nutrition services, palliative care and pharmaceutical services.
- Activities that promote health are supported by the primary health care system and include but are not limited to community capacity building to promote health, individual health education, disease and injury prevention and advocacy for healthy public policy.

Responsive and flexible.

This means that:

- Communities are supported in gathering and accessing reliable information to help identify changing capacities, needs and issues.
- The changing capacities and needs of individuals, families and communities are recognized and responded to in a timely manner.
- Primary health care services are offered in ways that value and respond to the cultural, racial, and spiritual experiences of individuals, families and communities.

Accessible.

This means that:

- Primary health care services are accessible to all Nova Scotians, as close as possible to where they live, work, or go to school.
- Nova Scotians can choose a primary care provider and have access to a defined range of primary health care services, including access to urgent care 24 hours a day.
- There is equity of access for those who have

historically faced barriers, including but not limited to barriers related to illness, disability, poverty, culture, race, ethnicity, language, geography and gender.

- Access to other primary, secondary and tertiary health care services is coordinated, and linkages are made with services outside the health care system including programs and services offered at the community level by a variety of providers and organizations.
- Activities that promote health are supported in all communities across the province.
- Specific mechanisms are in place to ensure that where both federal and provincial jurisdictions have responsibilities for service delivery (e.g. to First Nations), access is assured and coordinated.

Integrated, collaborative and innovative.

This means that:

- Health care services are coordinated and integrated in a way that ensures care is provided to individuals and families in the optimal setting, and assists individuals and families in navigating with ease through the system.
- Linkages are made and maintained with organizations, agencies and government departments whose contribution is essential to the improvement of individual, family and community health status.
- Collaboration within and outside the primary health care system results in creative, innovative and effective approaches to the delivery of health care services and to the implementation of activities that promote health.
- Collaboration among primary health care professionals, other care providers, community organizations, individuals and families is supported by structures that foster trust, support for shared decision-making and respect for professional autonomy.

Accountable.

This means that:

- Those who receive and provide care as well as those who govern the health system and work on behalf of communities have clearly defined and specific areas of accountability.
- Health information and data are available and accessible so that individual, family, community, health professional and government decision-making is based on sound evidence.
- There is ongoing evaluation of the primary health care system related to needs, standards, efficiency and effectiveness.
- Communities participate in identifying and supporting methods used to promote health and to deliver primary health care services.

Sustainable.

This means that:

- Those who govern the health system and work on behalf of communities ensure the delivery of quality activities to promote health and health care services that are efficient, effective, affordable, and acceptable to the community.
- Duplication and waste are identified and eliminated.
- Standards and best practices are widely adopted in the effort to sustain equitable, quality care across the province.
- Ongoing education and resources are available to support primary health care professionals in both their delivery of services and in collaborating with others.

Primary Health Care Renewal

Action for Healthier Nova Scotians

Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal

May, 2003

Primary Health Care Renewal: Action for Healthier Nova Scotians

Report of the Nova Scotia Advisory Committee on Primary Health Care Renewal

Presented to the Nova Scotia Department of Health, May, 2003

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May 14, 2003

The Honorable Jane Purves
Minister of Health
Province of Nova Scotia
1690 Hollis St.
Halifax, NS
B3J 2R8

Dear Minister:

On behalf of the Advisory Committee on Primary Health Care Renewal, I am pleased to submit this report with criteria and recommendations for the development of a community-based primary health care system. You will note that the end of the report suggests next steps that the committee believes are essential to the realization of a renewed primary health care system for Nova Scotia.

The committee understands that primary health care renewal is a step-wise, voluntary and evolutionary process. This report fulfills the mandate of the Advisory Committee and provides direction for a collaborative process of implementation.

The Advisory Committee is grateful for your support of its work and the opportunity to play a pivotal role in developing a primary health care system that will support the improved health status of Nova Scotians.

Yours sincerely,

David M. Rippey
Chair, Advisory Committee on Primary Health Care Renewal

cc Tom Ward, Deputy Minister of Health
Cheryl Doiron, Associate Deputy Minister of Health

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- Task Team on System Design and Governance
- Task Team On Existing and New Primary Health Care Providers
- Task Team on Primary Health Care Funding and Physician Remuneration
- The Staff of the Primary Health Care Section of the Department of Health

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REPORT OF THE ADVISORY COMMITTEE ON PRIMARY HEALTH CARE RENEWAL

EXECUTIVE SUMMARY

Why Change?

Primary health care is the foundation of any health system that supports the health and wellness of its population. A well-coordinated, integrated and sustainable primary health care system will improve the health status of Nova Scotians. At this time, the health status of Nova Scotians clearly shows the need to invest in prevention and take action to address the determinants of health for **all** Nova Scotians.

Nova Scotia has higher than national average mortality rates related to cancer, respiratory disease, pneumonia and influenza, and circulatory disease. Risk factors for chronic disease are also problematic, with higher than national average rates of obesity, smoking, and physical inactivity. Seven types of chronic illness alone (cardiovascular diseases, cancer, respiratory ailments, diabetes, musculoskeletal disorders, diseases of the nervous system and sense organs, and mental illness) cost the province more than $3.0 billion per year in direct medical costs and indirect productivity losses (GPI Atlantic, 2002).

Some Nova Scotian populations have been excluded from full participation in the heath care system because of poverty, ill health, gender, race or lack of education. Some do not feel welcome accessing care because the health care workforce does not reflect or understand their cultural or ethnic diversity. The statistical and health research gaps related to minority populations in Nova Scotia also complicate efforts to understand the effect of the interaction of the determinants of health, which have a greater impact on these populations.

Interdisciplinary teams that involve a variety of professionals are not well established in Nova Scotia's primary health care system. In addition to existing providers, such as nurses and family physicians, there are many other providers who can contribute to meeting the primary health care needs of individuals and communities.

Technology-based information systems that support effective and efficient primary care are not widely used, and there is poor information transfer between primary care providers and acute care centres. The inability to measure quality of care and the limited accountability for quality and costs results in the ineffective allocation of resources.

Because many of the factors that affect health lie outside of the health sector (i.e. the environment, employment status, education), collaboration with other government departments, the private sector and community organizations in primary health care is essential. The planning and service delivery linkages made between community-based organizations that are involved in primary health care are often ad hoc versus formally planned and supported. The system relies heavily on family caregivers and volunteer organizations that are not well resourced or integrated with the system.

Access can be an issue for those who have traditionally faced barriers due to poverty, ill health, gender, race, lack of education, disability, or sexual orientation. Many people go to emergency departments for primary care if they have no family physician or if theirs does not provide services at a time and place that is convenient for the client. Emergency departments are not organized in a way that provides a coordinated continuum of primary health care. When they become overburdened, their capacity for urgent and emergent care is limited and quality of care is affected.

While communities do participate in planning for the primary health care system through Community Health Boards, there is a need for even more community participation, especially by minority populations. Aboriginal people have been excluded from participation in policy and program development that would ensure that services and programs meet their needs. They have also faced barriers in accessing health services because of the jurisdictional issues between the federal and provincial governments.

Despite these challenges, many positive aspects of the existing primary health care system provide an excellent foundation for renewal efforts. The contribution of existing providers, including family physicians and public health providers for example, is recognized and highly valued. There are also many formal and informal planning and service delivery linkages taking place among community and public organizations. Nova Scotia's Community Health Boards ensure that Nova Scotians participate in health planning and are involved in identifying their health needs. And soon renewal efforts will be informed by the comprehensive evaluation of the Strengthening Primary Care Initiative demonstration projects that paved the way for the introduction of primary health care nurse practitioners, and advanced information technology in Nova Scotia's primary health care system.

Nova Scotia's Vision for Primary Health Care

The Advisory Committee on Primary Health Care Renewal (ACPHCR) was established in September 2001 to advise the Department of Health on the development of a community-based primary health care system. In November 2001, a group of approximately 150 primary health care stakeholders including the ACPHCR, policy and decision makers, front-line primary health care providers, and community representatives, developed a vision for primary health care in Nova Scotia. This vision has guided the work of the ACPHCR and it states that

In 15 years the health status of the population of Nova Scotia will be improved because individuals, families, communities, and non-government and government organizations within and outside the health sector have been enabled to positively influence the many factors that influence health.

Communities will be supported in their efforts to improve health by a primary health care system that is

Community-based, family-focused, and person-centred. This means that

- Everyone in the community (individuals, families, primary health care providers, community groups, service delivery organizations, and government) works together to identify and build upon community strengths and capacities, and to define community health needs and the best ways to meet them.
- The uniqueness and diversity of individuals, families, and communities are valued and responded to appropriately.
- Individual, family, and community capacities to improve health status and to participate in health services planning are increased.
- All Nova Scotians have an ongoing relationship with a primary health care provider through whom they can access health care services.

Comprehensive. This means that

- The many factors that influence health are considered in primary health care planning and delivery, including but not limited to income, social status, education, employment, healthy child development, genetic endowment, gender, culture, spirituality, and race.
- The primary health care system provides a balance between activities that promote health and activities that provide health care services.
- A wide range of services is offered by the primary health care system, including but not limited to primary care, continuing care (long term and home care), rehabilitative care, public health, emergency care, community mental health, addictions, nutrition services, palliative care, and pharmaceutical services.
- Activities that promote health are supported by the primary health care system and include but are not limited to community capacity building to promote health, individual health education, disease and injury prevention, and advocacy for healthy public policy.

Responsive and flexible. This means that

- Communities are supported in gathering and accessing reliable information to help identify changing capacities, needs, and issues.
- The changing capacities and needs of individuals, families, and communities are recognized and responded to in a timely manner.
- Primary health care services are offered in ways that value and respond to the cultural, racial, and spiritual experiences of individuals, families, and communities.

Accessible. This means that

- Primary health care services are accessible to all Nova Scotians, as close as possible to where they live, work, or go to school.
- Nova Scotians can choose a primary care provider and have access to a defined range of primary health care services, including access to urgent care 24 hours a day.
- There is equity of access for those who have historically faced barriers, including but not limited to barriers related to illness, disability, poverty, culture, race, ethnicity, language, geography, and gender.
- Access to other primary, secondary, and tertiary health care services is coordinated, and linkages are made with services outside the health care system including programs and services offered at the community level by a variety of providers and organizations.
- Activities that promote health are supported in all communities across the province.
- Specific mechanisms are in place to ensure that where both federal and provincial jurisdictions have responsibilities for service delivery (e.g. to First Nations), access is assured and coordinated.

Integrated, collaborative and innovative. This means that

- Health care services are coordinated and integrated in a way that ensures care is provided to individuals and families in the optimal setting and that assists individuals and families in navigating with ease through the system.
- Linkages are made and maintained with organizations, agencies, and government departments whose contribution is essential to the improvement of individual, family, and community health status.
- Collaboration within and outside the primary health care system results in creative, innovative, and effective approaches to the delivery of health care services and to the implementation of activities that promote health.
- Collaboration among primary health care professionals, other care providers, community organizations, individuals, and families is supported by structures that foster trust, support for shared decision-making, and respect for professional autonomy.

Accountable. This means that

- Those who receive and provide care as well as those who govern the health system and work on behalf of communities have clearly defined and specific areas of accountability.
- Health information and data are available and accessible so that individual, family, community, health professional, and government decision making is based on sound evidence.
- There is ongoing evaluation of the primary health care system related to needs, standards, efficiency, and effectiveness.
- Communities participate in identifying and supporting methods used to promote health and to deliver primary health care services.

Sustainable. This means that

- Those who govern the health system and work on behalf of communities ensure the delivery of quality activities to promote health and health care services that are efficient, effective, affordable, and acceptable to the community.
- Duplication and waste are identified and eliminated.
- Standards and best practices are widely adopted in the effort to sustain equitable, quality care across the province.
- Ongoing education and resources are available to support primary health care professionals both in their delivery of services and in collaborating with others.

Recommendations and Key Messages

While it is clear that *change is necessary*, the ACPHCR recommends an *incremental approach* that builds on the existing strengths and capacities of the existing system, and the *voluntary participation* of primary health care stakeholders.

The ACPHCR has also recommended criteria for primary health care governance, accountability, integration and linkages, settings, services and programs, contributors and funding. These criteria are intended to be a tool or checklist against which communities, primary health care organizations, District Health Authorities, and the Department of Health can check to ensure that their plans are consistent with the provincial vision for primary health care.

It is recognized that not all primary health care services, programs and organizations will initially be able to meet all of the criteria. However, in planning for primary health care participants should strive to meet as many of the criteria as possible.

Services and Programs

Many excellent primary health care services are provided by dedicated physicians, nurses and many other health providers in Nova Scotia today. However, changes are needed to ensure that all Nova Scotians have access to a comprehensive range of primary health care services that address the interaction of the determinants of health and contribute to the continuum of primary health care.

The ACPHCR recommends that the following services, over time, become the foundation of the primary health care system:

1. Basic Emergency Services
2. Communicable Disease Prevention and Control
3. Community Mental Health Services
4. Community Supports
5. Continuing Care (Home Care, Long Term Care, Small Options Homes, Palliative Care, etc.)
6. Dental Health Services
7. Environmental Health Services
8. Health Promotion (including community development)
9. Healthy Child Development
10. Nutrition Services
11. Primary Maternity Care
12. Prevention & Treatment of Common Diseases and Injuries
13. Rehabilitation Services
14. Sexual Health and Family Planning Services
15. Other publicly funded services (services such as housing, income assistance, occupational health & safety, and education programs that are delivered by other government departments)

Contributors

The term "contributors" is used to name those health care professionals ***and*** other persons whose work contributes to the health of individuals and communities. These include professionals (for example family physicians, nurse practitioners and public health providers), volunteers, family caregivers, neighbors, friends, and providers of alternative and complementary health care.

It is time to create new ways for existing and new contributors to work together to increase their impact on the health of Nova Scotians, and to increase the diversity of the primary health care workforce to make it more reflective of the entire Nova Scotia population.

The preferred future for primary health care providers is the interdisciplinary collaborative team, which consists of core and extended team members. Core providers are those who have a longer-term and continuing relationship with the client. Extended providers have shorter-term relationships at times when the client requires a specialized service. The core team includes the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider(s), and midwife.

The structure of the core and extended team will reflect the needs of the population being served. However, other factors such as geography will also affect the structure of a team. Communities and primary health care service delivery organizations may combine or coordinate their resources to ensure access to team members.

The declining number of family physicians and the lack of other providers of primary maternity care has lead to concern about the provision of primary maternity care services in Nova Scotia. The primary health care system should therefore support a collaborative team-based approach to the delivery of primary maternity care with the participation of family physicians and midwives. This would require the creation of a regulatory and/or licensing structure for midwives in Nova Scotia.

There are at least 86,000 family caregivers in Nova Scotia, many of whom experience significant negative consequences to their health and well being due to the demands of caregiving. Family caregivers should be involved in policy development and named in policies that affect them. Their needs should be assessed, and a range of supports (i.e. financial, emotional, information and education, and replacement care) should be available to them.

The literature indicates that the increasing utilization of complementary and alternative health care therapies in Canada has been led by consumer demand versus evidence of the effectiveness of treatment. Therefore, more work related to the possible relationship of complementary and alternative health care providers to the primary health care team must be conducted.

Integration and Linkages

There are many examples of informal types of integration taking place in Nova Scotia's primary health care system today, but the primary health care system is still not well coordinated and integrated. This results, for example, in gaps in care, lack of coordination between levels of care, and redundancies and duplication in the care process. A well coordinated, integrated, and sustainable primary health care system could improve the health status of Nova Scotians.

To achieve this, planned linkages, networks, strategies and functional integration among government departments, non-governmental organizations, communities, the academic sector, First Nations and other levels of care is required. Information and resources that contribute to individual and population health must be shared and mechanisms to assist individuals and families in navigating through the health care system and the broad range of community supports and services must be developed.

The development of confidential and common electronic patient records for each Nova Scotian is also key to integration within the primary health care system.

Governance

There is currently no single governance structure among primary health care organizations in Nova Scotia. However community governance, in some form, is common. Governance models that will lead Nova Scotia to its vision for primary health care are required. Such models would demonstrate that community participation is real and impacts decision-making, and, at the same time, would give providers the opportunity to influence the direction of the organization. They would support collaboration and facilitate linkages among agencies within and external to the primary health care system, aligning with the primary health care goals and objectives of their respective DHA or the IWK Health Centre. Such models would also ensure fiscal and clinical accountability, and the measurement of health outcomes. Communities should develop governance solutions that adapt to local situations.

Accountability

All Nova Scotians share responsibility for their health and the health of communities. The vision for primary health care articulates accountability in terms of a participative process and mutually agreed upon relationship. While legislation clearly defines some of the accountability relationships within the primary health care system, many accountability relationships are not clear, particularly to the public. Therefore, the accountabilities of all stakeholders must be clearly defined. There also needs to be a commitment to effective and innovative public consultation, public communication, community mobilization and participation, and functional integration in planning, health promotion, and primary health care service delivery.

Ongoing evaluation and supporting informed evidence-based decision making with performance and outcomes standards is key to establishing accountability relationships. Making information about their health needs, the goals of primary health care, and the benefits and costs of services available to individuals and families will allow individuals to take an increased role in decisions about their wellness.

Funding

In Nova Scotia, the Department of Health does not specifically designate funds for primary health care. Rather, it allocates a global budget to each of the nine DHAs, which in turn fund local health services such as acute care, emergency services, and some community health centres, and the IWK Health Centre. The DHAs do, however, have protected funding for public health, mental health, addiction services, and tobacco control programs. As compared to other Canadian provinces, Nova Scotia spends more in the areas of hospitals and physician services, and proportionately less in the areas of public health, administration, and capital expenditures, and has a lower health status than most other provinces.

Nova Scotia should move toward a population-based funding mechanism for primary health care in an evolutionary and incremental manner. Population-based funding is a mechanism, or a mix of mechanisms, that attempts to match resource allocation to different levels of health status, health care needs, and services required to serve different populations. The objectives of population-based funding should be to

- improve access and continuity of health services
- promote integration of health services
- enhance health promotion and illness prevention
- support the most appropriate health care provider, or team of providers, to provide primary health care services in the most appropriate settings
- provide incentives to improve quality, effectiveness and efficiency where evidence and/or best practice supports those improvements

Models of Primary Health Care Service Delivery

A wide range of models of primary health care service delivery exists within Canada and other jurisdictions, each of which meets the proposed criteria for primary health care to varying degrees. The literature and evidence are clear that no single model will meet the needs of all communities, and as such communities must work together to develop primary health care service delivery models that best reflect their assets and meet their needs. Participation in these models by providers and communities must be voluntary, allowing gradual movement toward models that reflect the broader primary health care approach.

Change Management

Given the complexity of primary health care renewal and the need to shift attitudes and behaviors of not only the public, but also providers and policy makers, multiple change management strategies will be required if primary health care renewal is to be achieved.

Leadership for the development of this multi-level strategy should be taken by the Department of Health and it must involve all partners DHAs, CHBs and communities, providers, the public, and populations that are traditionally excluded from primary health care. Involvement of all stakeholders will increase the likelihood of acceptance and adoption of change.

The Department of Health and DHAs must also dedicate adequate funding and resources to support the change management strategy. Skilled transition and change managers must be recruited to champion the change process at the Department of Health and DHAs levels, and the Department of Health should work with the Office of Health

Promotion on relevant activities.

Change management must be supported by a mechanism for evaluation that will support program evaluation and ongoing improvements at the community level while allowing for regional and national comparisons.

Information technology and information management in primary health care must be in line with the provincial health information strategy. Specific change management activity must also support the implementation of electronic patient records.

Next Steps

While an incremental and voluntary approach to primary health care renewal will be key to its success, there are a number of activities that must take place in the immediate future so that primary health care renewal can be begin.

These include

1. The Department of Health publicly endorsing the direction recommended by the ACPHCR
2. The Department of Health securing a commitment to a sustainable resource plan for the primary health care system, including a commitment to information technology and human resources for expanded interdisciplinary teams
3. As part of this resource plan, the Department of Health and DHAs commit to dedicated funding for CHBs to ensure that they have adequate resources to fulfill their legislated mandate. By doing so, the critical role that volunteers play in the health care system will be recognized.
4. The Department of Health, DHAs and the IWK Health Centre working together to undertake planned and thorough marketing and communication of the contents of the report to educate the public and other primary health care stakeholders about primary health care renewal in Nova Scotia
5. The Department of Health, DHAs and the IWK Health Centre working together to make information available so that all Nova Scotians understand the health issues and health status of their geographic, cultural, and ethnic communities. This involves the dedication of resources to support gathering and sharing this information and to building the capacity of the community to use the information
6. The Department of Health leading and working with DHAs and the IWK Health Centre to develop timelines and implement the change management strategy identified in this report
7. The Department of Health developing a strategy to overcome the jurisdictional issues that are barriers to the full participation of First Nations in the planning and delivery of primary health care
8. The Department of Health working with DHAs, the Medical Society of Nova Scotia, and others to develop options for alternative funding arrangements for family physicians that supports the direction of primary health care renewal
9. In order to learn from our experiences in primary health care renewal, the Department of Health working with DHAs and the IWK Health Centre to develop a tool or mechanism to measure health outcomes and the impact of changes to primary health care. The tool should
   a. allow for the creation of a baseline of information on the performance and outcomes of the current system
   b. provide for the sharing of information with communities, CHBs, DHAs, the IWK Health Centre and other health planners
   c. ensure the consistent methods of information collection across DHAs and the IWK Health Centre.

KEY DEFINITIONS

Primary Health Care

Primary health care is concerned with all the factors that promote health as they apply to a given population, not just personal health services. It addresses the factors that determine health. These include things such as income, social status, social support networks, education, employment, working conditions, social environment, physical environments, biology and genetic endowment, personal health practices and coping skills, healthy child development, health services, gender, and culture. These factors are recognized and addressed within a system that has appropriate linkages, both with other components of the health care system and with all other related sectors and aspects of provincial and community development, such as community groups, family caregivers, volunteer organizations, government departments and agencies, and others.

Primary health care is developed with the full participation of the people it serves. It empowers people to take care of their own health and to take an active part in planning, policy making, and delivering health services in their community. Primary health care requires a strong foundation of community-based services that enable people to maintain and strengthen their health. Primary health care services include health education and promotion, prevention, rehabilitation, and support and treatment for illness and injury (definition adapted from Task Force on Primary Health Care, 1994, and Health Canada's Taking Action on Population Health, 1998).

Primary Care

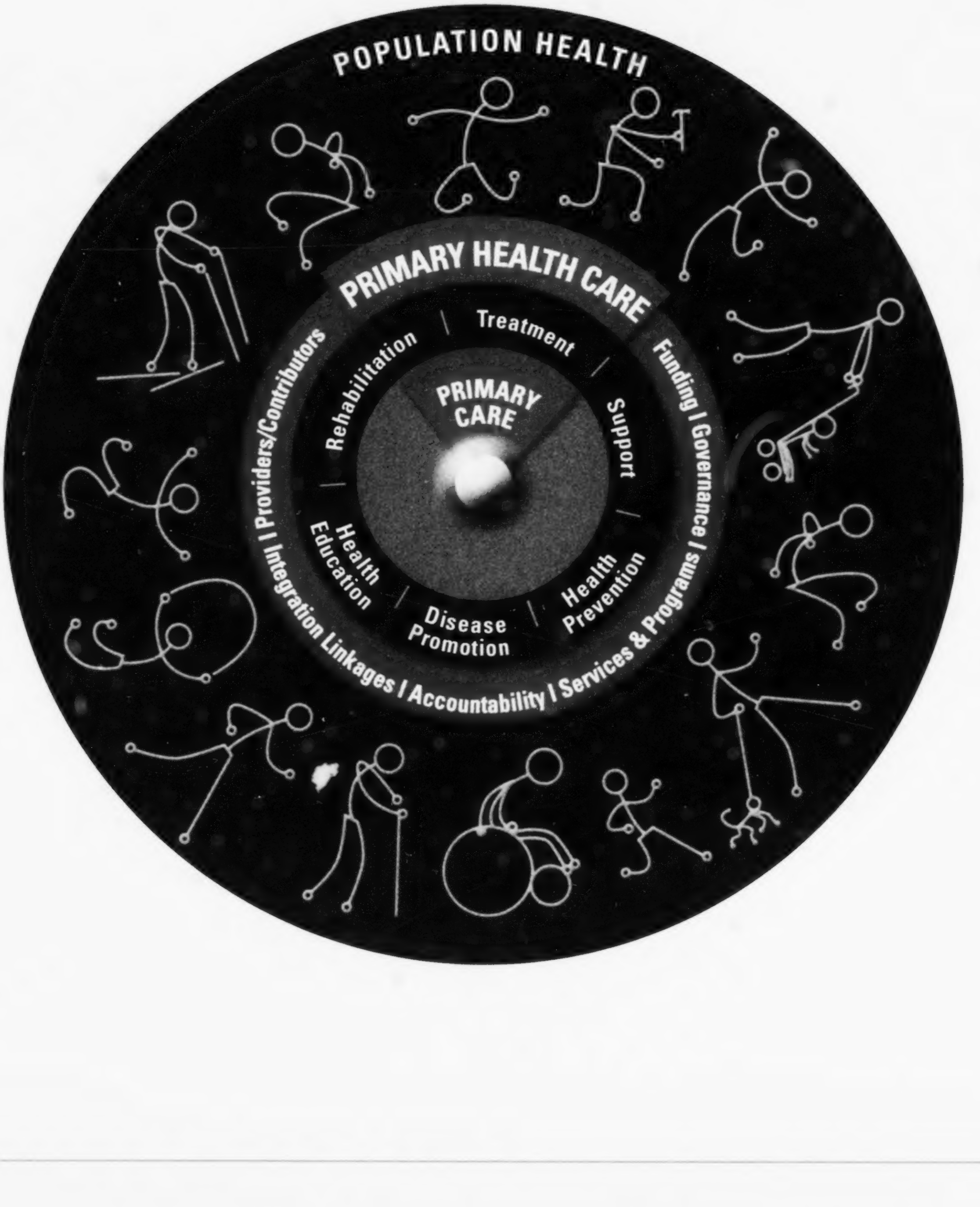
Primary care is one aspect of primary health care. It is the individual's or family's initial and continuing contact with the health care system. The focus of primary care is on service delivery. Primary care services include health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, education, and advocacy (Nova Scotia Department of Health, 1999).

Population Health Approach

The population health approach is a conceptual framework for thinking about health. The overall goal of the approach is to maintain and improve the health of the entire population and to reduce inequalities in health between population groups. In a population health approach, the entire range of known (i.e. evidence-based) individual and collective factors and conditions that determine population health status, and the interactions among them, are taken into account in planning action to improve health.

Population health and primary health care are similar in that they focus on the broad determinants of health, rely on inter-sectoral collaboration, are committed to accountability and evidence, and involve working with communities to find solutions. Primary health care is different from population health in that it has a service delivery component that is targeted to individuals, families and communities. The diagram on the following page illustrates the relationship or interface between primary care, primary health care and population health.

Diagram One: Relationship between primary care, primary health care and population health



SECTION ONE

WHY CHANGE?

Key Messages

- **A well-coordinated, integrated and sustainable primary health care system is needed to improve the health status of Nova Scotians**
- **Many positive aspects of the existing primary health care system provide an excellent foundation for renewal efforts**
- **Taking an incremental and voluntary approach, action to address the determinants of health, and investing in prevention are key to the success of primary health care renewal**
- **Taking a population health approach and a social and economic inclusion perspective in primary health care renewal will positively impact on the health of Nova Scotians**
- **Reaching the ultimate goal of improving the health status of Nova Scotians will take time and the commitment of the many primary health care stakeholders, including the public**

Primary health care is the foundation of any health system that supports the health and wellness of its population. A well-coordinated, integrated and sustainable primary health care system will improve the health status of Nova Scotians. At this time, the health status of Nova Scotians clearly shows the need to invest in prevention and take action to address the determinants of health for all Nova Scotians.

Some of the significant challenges to the health status of the population include:

Health promotion and disease and injury prevention receive inadequate attention and there is a lack of infrastructure and resources to adequately support moving in this direction. This is a major concern given the province's higher than national average mortality rates related to cancer, respiratory disease, pneumonia and influenza, and circulatory disease. Risk factors for chronic disease are also problematic, with higher than national average rates of obesity, smoking, and physical inactivity.

Seven types of chronic illness (cardiovascular diseases, cancer, respiratory ailments, diabetes, musculoskeletal disorders, diseases of the nervous system and sense organs, and mental illness) cost the province more than $3.0 billion per year in direct medical costs and indirect productivity losses. Various socioeconomic characteristics of the population such as poverty, inequality, poor education, and environmental causes such as pollutants also contribute to chronic illness and costs to the system. Low-income groups have higher rates of smoking, obesity, physical inactivity and cardiovascular risk. Excess use of physician services due to educational or income inequality costs the health care system almost $70 million a year (GPI Atlantic, 2002).

There is a significant lack of information about the health status of Nova Scotians especially African Canadians, immigrants, and First Nations. These statistical and health research gaps complicate efforts to understand the effect of the interaction of the determinants of health on these populations who are often most vulnerable to them.

The various government departments and community organizations could improve the health of Nova Scotians by increasing collaborative efforts. Because many of the factors that affect health lie outside of the health sector (i.e. the environment, employment status, education), collaboration with other government departments, the private sector and community organizations in primary health care is essential.

The services provided by different primary health care professionals are not well integrated. Interdisciplinary teams that involve a variety of professionals are not well established in Nova Scotia's primary health care system. Most family physicians work in independent solo or group physician practices and there is insufficient integration of physician services with other parts of the health care system. Very few nurses and even fewer nurse practitioners work in the primary health care system even though evidence from elsewhere clearly demonstrates the important role they have in contributing to effective primary health care. There are also many other existing and new providers who can contribute to meeting the primary health care needs of individuals and communities.

There is a need to increase the diversity of the health care workforce to make it more reflective of the entire Nova Scotia population. The health care workforce does not reflect the cultural and ethnic diversity of the larger population. Local research indicates that this results in some minority populations not using the formal health care system except for emergency purposes or as a last resort because it does not reflect them and their experiences.

There is a need to increase the diversity of the health care workforce to make it more reflective of the entire Nova Scotia population.

Technology that supports primary health care is not well utilized or resourced. Technology-based information systems to support effective and efficient primary health care are not widely used, and there is poor information transfer between primary health care providers and acute care centres. There is also limited use of the existing telehealth network and there are no teletriage or e-health (web-based information applications) approaches available to the public and providers.

The primary health care system is not well integrated, coordinated, or resourced. One example of this is family caregivers who provide a substantial amount of primary health care in Nova Scotia, along with volunteers who work through community organizations that do not have sustainable funding and are not linked with other components of the primary health care system. There are also numerous examples of innovative primary health care initiatives that may or may not fall within the formal health system, such as youth health centres, community-based action teams that implement heart health promotion initiatives at the community level, and programs that enhance the capacity of communities to take action on their identified health priorities. Despite the success of these initiatives, planning and service delivery linkages made between organizations involved in primary health care are often ad hoc versus formally planned and supported.

Sustainability of the system is unsure due to a number of factors. The inability to measure quality of care and limited accountability for quality and costs results in the ineffective allocation of resources. For instance, volume driven financial incentives for some patient-care activities may disadvantage primary care physicians who would prefer to work in a team environment.

Access is a problem. Access can be an issue for those who have traditionally faced barriers due to poverty, ill health, gender, race, lack of education, disability, or sexual orientation. Many people go to emergency departments for primary care if they have no family physician or if theirs does not provide services at a time and place that is convenient for the client. Emergency departments are not organized in a way that provides a coordinated continuum of primary health care. When they become overburdened, their capacity for urgent and emergent care is limited and quality of care is affected.

While communities do participate in planning for the primary health care system through CHBs, there is a need for even more community participation. Inadequate community participation results in the inadequate identification of and response to populations that are in the greatest need. The lack of participation by minority populations is particularly problematic as it compromises efforts to understand and consider multiple perspectives in health service delivery.

The Aboriginal population faces jurisdictional barriers in the provision of health care services both on and off the reserve. Often Aboriginal people are excluded from accessing adequate or appropriate health services because of the jurisdictional barriers between federal and provincial governments. In addition, there is a lack of inclusion in policy and program development at both levels of government that would ensure that services and programs meet their needs. Recognition of and commitment to addressing the primary health care needs of Aboriginal people in Nova Scotia and Canada is required as a prerequisite to taking appropriate steps to provide health services to a population who face some of the worst health outcomes in our population.

A renewed primary health care system that is based on a population health approach and incorporates a social and economic inclusion perspective (i.e., including those who have traditionally been excluded because of poverty, ill health, gender, race, lack of education, disability or sexual orientation) will positively affect the health outcomes of Nova Scotian populations. Key to this renewal is taking an incremental and voluntary approach to change, and taking action to address the determinants of health, health inequities, the burden of chronic disease, and investing in prevention.

Nova Scotians - Who Are We?

Nova Scotia is home to just over 940,000 people of diverse ethnic, language, cultural, geographic, educational, and economic backgrounds.

The urban/rural split of the population was 55 per cent urban, 45 per cent rural in 1996 (Statistic Canada, 1996).

The unemployment rate was 9.7 per cent in 2001. The National rate at this time was 7.2 per cent. (Nova Scotia Department of Finance, 2002).

The Atlantic provinces have the highest low-literacy rates in Canada (Statistics Canada, 1996). Canadians with low literacy skills are more likely to be unemployed and poor, to suffer poorer health, and to die earlier than Canadians with higher literacy levels (Health Canada, 1999).

Visible minorities made up 3.8 per cent of the provincial population (approximately 34,000) as of January 2003. Blacks represent more than half (57 per cent) of this population, followed by Arabs (10.5 per cent), Chinese (9.5 per cent) and South Asians (8.4 per cent) (Nova Scotia Department of Finance, 2003).

The lack of participation by minority populations is particularly problematic as it compromises efforts to understand and consider multiple perspectives in health service delivery.

There were approximately 17,000 people with an Aboriginal identity in Nova Scotia in 2001. This represents 1.9 per cent of the total population (Nova Scotia Department of Finance, 2003).

Ninety three per cent of the population was anglophone and almost 4 per cent was francophone in 2001. The remaining three per cent of the population learned Arabic (0.5 per cent), Mi'kmaq (0.4 per cent), or German (0.3 per cent) as their first language in their home (Nova Scotia Department of Finance, 2003).

Almost 94 per cent of francophones could speak English (higher than the national average of 43 percent) and only 6.4 percent of Anglophones could speak French (lower than the national average of 9 per cent) in 2001 (Nova Scotia Department of Finance, 2003).

A vast and committed network of volunteers, family caregivers, and community contributors has also demonstrated their commitment to their communities and to supporting primary health care in this province.

Building on Our Strengths

Despite the many challenges facing the health status of Nova Scotians, many positive aspects of the existing primary health care system provide an excellent foundation for renewal efforts.

The contribution of existing providers to the primary health care system is recognized and highly valued. Family physicians, for instance, have and will continue to play a key role in the delivery of primary health care services in Nova Scotia. Similarly, the role of public health in achieving a healthy population is crucial. These and other provider groups are committed to the concept of primary health care renewal.

Many valuable planning and service delivery linkages are taking place involving, for example, community health centres, public schools, academic institutions, community-based non-profit and non-governmental organizations, and various government departments.

A vast and committed network of volunteers, family caregivers, and community contributors has also demonstrated their commitment to their communities and to supporting primary health care in this province.

In January 2001, Nova Scotia's 37 Community Health Boards (CHBs) gained a strengthened role under Bill 34, the Health Authorities Act. The Act gives Nova Scotia communities the strongest role in the country in terms of community input into health system planning. CHBs nominate two thirds of the seats on District Health Authority Boards. The role of CHBs includes assessing the health needs of their communities and developing community health plans.

In 2000, the Strengthening Primary Care Initiative (SPCI) saw the establishment of primary care demonstration projects in four communities throughout Nova Scotia. The SPCI has provided the opportunity to evaluate options for collaborative practice, information management, and alternative funding for physicians. Evaluation of the Strengthening Primary Care Initiative is ongoing. Lessons learned from the Initiative will continue to inform primary health care renewal efforts.

While the term "renewal" is relatively new, specific activity around primary health care renewal is not. In 1994, the Nova Scotia Task Force on Primary Health Care submitted a report and recommendations to the Nova Scotia Department of Health that addressed important primary health care issues such as coordination, access, and accountability, and outlined different ways of providing primary health care in Nova Scotia. Since this time, a variety of successful activities have taken place as part of the ongoing renewal process. These include:

- The decentralization of health system governance to a model that involves nine District Health Authorities (DHAs) that have responsibility for a range of services along the health care continuum including primary health care.
- The enhancement of community involvement in health planning through the development of community health boards.
- Legislative changes to expand the range of providers of primary care to include nurse practitioners.
- Planning for structural changes such as the integration of long term care and home care with DHA services, increased options for alternative remuneration for physicians, and the development of single entry access for long term care and home care.
- The Strengthening Primary Care Initiative (SPCI) saw the establishment of primary care demonstration projects in four communities throughout Nova Scotia. Over time, some of these sites expanded from primary care into primary health care and all of them have become sustainable primary health care organizations.
- The creation of the multi-stakeholder ACPHCR to provide advice to the Department of Health about the development of a community-based primary health care system.
- Broad stakeholder participation in the development of a vision for the future of primary health care in Nova Scotia.

Primary health care renewal will build upon the existing strengths and capacities of the existing system. Reaching the ultimate objective of improving the health status of Nova Scotians will take time and the commitment of the many primary health care stakeholders.

SECTION TWO

BACKGROUND AND CONTEXT FOR PRIMARY HEALTH CARE RENEWAL

Background and Context for Primary Health Care Renewal

Key Messages

- **Since 1999, major health system review reports in Saskatchewan, Quebec, Alberta, New Brunswick, and Ontario have identified issues and made recommendations in the area of primary health care renewal or reform**
- **In 2001, the Nova Scotia Department of Health identified primary health care as a strategic direction of the organization and as such created the Advisory Committee on Primary Health Care Renewal to advise the Department on the development of a community-based primary health care system**
- **The ACPHCR report will inform the implementation of activities related to the Primary Health Care Transition Fund, which include implementing enhancements to primary health care services and creating new primary health care networks/organizations, supporting "change costs" and transitioning the primary health care system to an electronic patient record**

National Environment

Since 1999, major health system review reports have been released in the provinces of Saskatchewan, Quebec, Alberta, New Brunswick, and Ontario. A Senate Committee report and the federal Commission on the Future of Health Care in Canada have also released reports recommending change to Canada's health care system. Each of these reports has identified issues and made recommendations in the area of primary care and primary health care renewal or reform.

The reports suggest there is a need for new models of primary health care delivery and that these models would be characterized by increased integration, networks or multi-disciplinary teams of providers, increased comprehensiveness of services, and access via 24 hour 7 days per week availability. In the area of governance, many of the reports suggest that primary health care organizations and services should be governed under a single governance structure at a regional or district level. All of the reports recommend that electronic health records and other information-related technology (such as smart cards and telehealth) are required for improvements to primary health care.

To encourage innovative approaches to delivery, the reports recommend making changes to the way that physicians are paid. Proposed alternatives include incentive structures, salary, and population-based or blended payment.

The need for population health goals or targets and the ability to measure their achievement is also a popular theme among the reports. The need for accountability was recognized and some mechanisms were proposed.

Many of the reports identify the need for mechanisms to address the complex jurisdictional issues related to the delivery of primary health care to First Nations. In addition, the Final Report of the Commission on the Future of Medicare (the Romanow Report), which was released in November of 2002, specifically recommends addressing the diverse health needs of Canadians. Within this context, the Romanow Report notes access concerns and identifies the unique needs of the francophone population, visible minorities, new Canadians, and persons with disabilities.

The Romanow Report provided a national perspective on health care and further support for primary health care renewal. It identifies a number of issues facing the primary health care system in many Canadian jurisdictions that are similar to those identified in Nova Scotia. These include continuity of care, insufficient focus on primary health promotion and illness prevention, inadequate health data and information to assist evidence-based decision-making, and a lack of incentives to manage change to a renewed primary health care system.

The Romanow Report also recommended that a new Primary Health Care Transfer should be established and used by the provinces and territories to 'fast-track' changes to primary health care in four areas that it deems are the 'essential building blocks'. These are continuity of care, early detection and action, better information on needs and outcomes, and new and stronger incentives to achieve transformation of the primary health care system. In response to these recommendations, in February 2003, the provinces, territories and federal governments signed a five-year agreement called the Health Care Renewal Accord 2003 (Health Accord). The Health Accord established the Health Renewal Fund, which will transfer resources to the provinces and territories to address primary health care, home care, and catastrophic drug coverage over the next five years.

Department Of Health Strategic Directions

In 2001, the Department of Health recognized the need to make changes and identified primary health care as a strategic direction of the organization. One of the Department's eight strategic directions for 2002-03 was to design and implement a primary health care system that meets the needs of Nova Scotians. Strategic directions for 2003-04 include a commitment to 'champion wellness for improved health status of Nova Scotians' and to 'facilitate the provision and promotion of equitable access to health services'. The Department is committed to a population health approach and primary health care renewal as a strategic priority through 2003-04.

The Advisory Committee on Primary Health Care Renewal

In response to the need to renew the primary health care system, the Advisory Committee on Primary Health Care Renewal (ACPHCR, Committee) was created in September of 2001. The Committee's mandate was to advise the Nova Scotia Department of Health on the development of a community-based primary health care system, specifically:

- Assist in the development of a vision and principles for a community-based primary health care system
- Advise the Department of Health on priorities for the use of the Primary Health Care Transition Fund
- Identify community-based primary health care networks/organizations for consideration
- Develop the criteria and components of these models
- Promote linkages between the primary health care system and other sectors
- Identify opportunities to collaborate with other sectors to achieve health status improvements among Nova Scotians

The philosophy of population health is key to the ACPHCR's approach to primary health care renewal. A 'Population Health Checklist' was developed to provide the ACPHCR with a quick reference to the population health guiding principles and to be able to reflect on whether or not their work was in keeping with a population health approach. This complete checklist can be found in Appendix Three.

This report is the culmination of the Committee's work and outlines its recommendations to the Department of Health around these issues. The complete Terms of Reference of the ACPHCR can be found in Appendix Two.

Primary Health Care Transition Fund

In 2001, Health Canada announced the establishment of an $800 million Primary Health Care Transition Fund (PHCTF). Seventy per cent of this fund is to be distributed to the provinces and territories on a per capita basis and the remaining 30 per cent for distribution across the country to projects of national significance.

In July 2001, the Department of Health was required to submit to Health Canada its proposal outlining plans for Nova Scotia's portion of the Primary Health Care Transition Fund. This resulted in the need to simultaneously coordinate the ACPHCR process and the PHCTF proposal development process. To ensure consistency and linkages between the two processes, the Committee and DHAs participated in the identification of priorities for the PHCTF and the development of the proposal to Health Canada.

The proposal identified three transition initiatives:

implementing enhancements to primary health care services and creating new ways to develop sustainable primary health care networks/ organizations

supporting "change costs"

transitioning the primary health care system to an electronic patient record

The implementation of activities within each of the three proposed initiatives will be further informed by the ACPHCR's report.

Diversity and Social Inclusion in Primary Health Care Initiative

Nova Scotia's vision for primary health care

- recognizes need for primary health care services that value and respond to the cultural, racial and spiritual experiences of individuals, families, and communities
- requires that equity of access be established for those who have historically faced barriers (race, ethnicity, language and culture), understanding that these and other interrelated factors determine the health of Nova Scotians

Based on this, the Department has created the Diversity and Social Inclusion in Primary Health Care Initiative to begin to effectively address the needs of Nova Scotia's culturally diverse populations. The Initiative's three-year plan will raise awareness of diversity and social inclusion issues in primary health care, and, through consultation with stakeholders including culturally diverse populations, develop guidelines and policies for the primary health care system.

Methodology

The recommendations of the ACPHCR were developed using a consultative approach. The Committee consisted of representatives of a variety of health professions, health services delivery organizations such as DHAs, community health centres and the IWK Health Centre, the academic community, community health boards, First Nations, and African-Nova Scotian communities.

The vision was developed with input from over 150 partners in primary health care, including ACPHCR members, policy and decision makers, front-line primary health care providers, and community representatives.

A number of task teams conducted work for the ACPHCR in the specific areas of system design, integration, services and programs, providers, and funding. These task teams also had multi-stakeholder representation from the selected health professions, not-for-profit community-based organizations, DHAs, Department of Health and in some, cases inter-sectoral representation. In addition to the work of the task teams, other papers and reports were brought forward to the Committee for their consideration. The recommendations in this report are the result of rigorous analyses and debates of the ideas put forward in these various pieces of work.

Report Format

This report is organized into five major sections. The first section focuses on the rationale for primary health care renewal. The second section provides the background and context for the ACPHCR's work, including the vision and criteria for primary health care.

The third section focuses on the central components of the primary health care system. These include services and programs, contributors, integration and linkages, and models of service delivery. They are the "face" or "front line" of primary health care as experienced by the public and providers.

The fourth section focuses on essential supporting structures, which include governance, accountability, funding, change management, evaluation and information technology. These are the structures that are necessary to support and sustain the central components. Without them, the central components could not work to form a primary health care system.

- The last section of the report identifies key next steps that are required to ensure the realization of primary health care renewal in Nova Scotia.

Vision for Primary Health Care

In order to develop a community-based primary health care system, a broad provincial vision that would be the common vision of the many primary health care stakeholders was required. The Department of Health hosted a workshop attended by over 150 diverse stakeholders and engaged them in discussion about the primary health care needs of Nova Scotians. Efforts were made to include the perspective of stakeholders who had traditionally faced barriers to participation in health care decision-making. The resulting vision is the broad context within which the work of the ACPHCR was conducted.

Vision: ...individuals, families, communities, and non-government and government organizations within and outside the health sector have been enabled to positively influence the many factors that influence health.

Vision

In 15 years the health status of the population of Nova Scotia will be improved because individuals, families, communities, and non-government and government organizations within and outside the health sector have been enabled to positively influence the many factors that influence health. Communities will be supported in their efforts to improve health by a primary health care system that is

Community-based, family-focused, and person-centred.

This means that

- Everyone in the community (individuals, families, primary health care providers, community groups, service delivery organizations, and government) works together to identify and build upon community strengths and capacities, and to define community health needs and the best ways to meet them.
- The uniqueness and diversity of individuals, families, and communities are valued and responded to appropriately.
- Individual, family, and community capacities to improve health status and to participate in health services planning are increased.
- All Nova Scotians have an ongoing relationship with a primary health care provider through whom they can access health care services.

Comprehensive.

This means that

- The many factors that influence health are considered in primary health care planning and delivery, including but not limited to income, social status, education, employment, healthy child development, genetic endowment, gender, culture, spirituality, and race.
- The primary health care system provides a balance between activities that promote health and activities that provide health care services.
- A wide range of services is offered by the primary health care system, including but not limited to primary care, continuing care (long term and home care), rehabilitative care, public health, emergency care, community mental health, addictions, nutrition services, palliative care, and pharmaceutical services.
- Activities that promote health are supported by the primary health care system and include but are not limited to community capacity building to promote health, individual health education, disease and injury prevention, and advocacy for healthy public policy.

Responsive and flexible.

This means that

- Communities are supported in gathering and accessing reliable information to help identify changing capacities, needs, and issues.
- The changing capacities and needs of individuals, families, and communities are recognized and responded to in a timely manner.
- Primary health care services are offered in ways that value and respond to the cultural, racial, and spiritual experiences of individuals, families, and communities.

Accessible.

This means that

- Primary health care services are accessible to all Nova Scotians, as close as possible to where they live, work, or go to school.
- Nova Scotians can choose a primary care provider and have access to a defined range of primary health care services, including access to urgent care 24 hours a day.

- There is equity of access for those who have historically faced barriers, including but not limited to barriers related to illness, disability, poverty, culture, race, ethnicity, language, geography, and gender.
- Access to other primary, secondary, and tertiary health care services is coordinated, and linkages are made with services outside the health care system including programs and services offered at the community level by a variety of providers and organizations.
- Activities that promote health are supported in all communities across the province.
- Specific mechanisms are in place to ensure that where both federal and provincial jurisdictions have responsibilities for service delivery (e.g. to First Nations), access is assured and coordinated.

Integrated, collaborative and innovative.

This means that

- Health care services are coordinated and integrated in a way that ensures care is provided to individuals and families in the optimal setting and that assists individuals and families in navigating with ease through the system.
- Linkages are made and maintained with organizations, agencies, and government departments whose contribution is essential to the improvement of individual, family, and community health status.
- Collaboration within and outside the primary health care system results in creative, innovative, and effective approaches to the delivery of health care services and to the implementation of activities that promote health.
- Collaboration among primary health care professionals, other care providers, community organizations, individuals, and families is supported by structures that foster trust, support for shared decision-making, and respect for professional autonomy.

Accountable.

This means that

- Those who receive and provide care as well as those who govern the health system and work on behalf of communities have clearly defined and specific areas of accountability.
- Health information and data are available and accessible so that individual, family, community, health professional, and government decision making is based on sound evidence.
- There is ongoing evaluation of the primary health care system related to needs, standards, efficiency, and effectiveness.
- Communities participate in identifying and supporting methods used to promote health and to deliver primary health care services.

Sustainable.

This means that

- Those who govern the health system and work on behalf of communities ensure the delivery of quality activities to promote health and health care services that are efficient, effective, affordable, and acceptable to the community.
- Duplication and waste are identified and eliminated.
- Standards and best practices are widely adopted in the effort to sustain equitable, quality care across the province.
- Ongoing education and resources are available to support primary health care professionals both in their delivery of services and in collaborating with others.

Criteria for Primary Health Care

What are Criteria?

A key accomplishment of the ACPHCR is the development of criteria for primary health care. But just what is meant by criteria and how are they to be used?

The vision for primary health care is a conceptual framework that outlines the principles and ideals that Nova Scotians' value and want to achieve as we strive to renew our primary health care system. However, more concrete guidelines that will enable planners (whether they are communities, groups of providers, primary health care organizations, DHAs, or the Department of Health) to operationalize or apply these concepts are required. The criteria for primary health care are these concrete guidelines. They are intended to be a tool or checklist against which any planner or planning body can determine if their ideas are consistent with Nova Scotia's vision for primary health care.

Development of the Criteria

The development of the criteria for primary health care was an iterative process that began with the Task Team on System Design and Governance. They identified a number of key components of a primary health care system including governance, integration and linkages, accountabilities, settings, services and programs, contributors, and funding. The task team developed the first proposed criteria in each of these areas and presented them to the ACPHCR for consideration.

The ACPHCR also received further detailed work in the areas of governance, linkages and integration, services and programs, providers/contributors, and funding. These pieces of work informed the ACPHCR, allowing them to further develop and refine the criteria in each of these respective areas. A number of large and small group exercises were conducted to facilitate consideration, discussion, and debate among the ACPHCR. The end result is a set of criteria, each of which has been individually considered and approved by the ACPHCR. The final criteria do not stand alone from the vision for primary health care, but are seen as a complement to it.

Criteria for Primary Health Care

All Nova Scotians share responsibility for their health and the health of their communities. This document presents criteria that can be used by communities, primary health care organizations, District Health Authorities, and the Department of Health to ensure that their primary health care plans are consistent with the provincial vision for primary health care. It is recognized that not all primary health care services and programs will initially be able to meet all of the criteria. However, planning for primary health care should meet as many of the criteria as possible in order to ensure that Nova Scotia progresses toward achieving the provincial primary health care vision.

As outlined in the provincial vision for primary health care, the continuum of primary health care includes self-help, advocacy, heath promotion, disease prevention, primary care, continuing care, rehabilitation, and palliative care.

Services and Programs

1. Services and programs proactively address the interaction of the determinants of health.
2. Services and programs contribute to the continuum of primary health care.
3. Services and programs are delivered in a collaborative manner.
4. Services and programs are sustainable.
5. Services and programs are based on available evidence and best practices.

6. Services and programs are provided in a manner and at times and locations that are flexible and accessible for individuals and communities.
7. Services and programs foster cooperation among communities and are established in a way that allows communities with different capacities the opportunity to meet their needs.
8. Services and programs provide entry points to a comprehensive, seamless system that promotes continuity of care.

Contributors:

The term "contributors" is used to name those health care professionals and other persons whose work contributes to the health of individuals and communities.

9. Providers and contributors work as a team.
10. Primary health care delivery involves health care providers and other contributors that reflect and are responsive to the needs of the community.
11. Collaboration or partnerships among providers and/or the community, whether formal or informal, are supported and/or enabled by one or more mechanisms which may include but are not limited to collaborative practice agreements, health promotion networks, intersectoral continuing education programs, networks and contractual agreements, team meetings, administrative coordination and support, and other supports and linkages.
12. To ensure quality and continued contribution, providers and contributors are supported by
    a. flexible and alternative arrangements and mechanisms such as alternative payment options and flexible working hours that address lifestyle issues and are responsive to community needs
    b. ongoing education and resources that support primary health care providers both in their delivery of services and in collaborating with others
13. The role of contributors and the role and scope of practice of providers are developed collaboratively and are clearly defined in the context of service delivery.
14. Training of new primary health care providers reflects the desired models of primary health care.

Integration and Linkages

15. Opportunities for the development of planned linkages, networks, strategies, and functional integration exist among all sectors within primary health care (including governmental, non-governmental, community, academic sectors, and First Nations) and between primary health care and the secondary and tertiary health care systems.
16. Planned and organized sharing of information and resources that contribute to individual and population health takes place over time with the development of respect and trust among primary health care stakeholders and between primary health care and secondary and tertiary health care stakeholders.
17. Individuals have a confidential, common health record that includes a basic health history and current health status and may be accessed by their choice of providers with the individual's agreement.
18. Individuals and families are assisted in navigating through the health care system and the broad range of community supports and services.

Settings

19. A variety of settings and mechanisms for the delivery of primary health care services are established with community consultation.

Governance

20. The governance model(s) demonstrates that community participation is real and makes an actual impact on the decisions made by the organization.

21. The governance model(s) gives providers the opportunity to influence the direction of the organization.

22. The governance model(s) addresses the issues of trust, commitment and interdependence between providers accustomed to working independently.

23. The governance model(s) nurtures and supports collaboration by the adoption of common goals that are singularly unattainable and by the development and adoption of collaborative practice agreements.

24. The governance model(s) includes a fiscal accountability framework.

25. The governance model(s) ensures that health outcomes are measured.

26. The governance model(s) includes a framework for clinical accountability.

27. The governance model(s) provides flexibility so that communities and organizations can develop governance solutions that adapt to local situations.

28. The governance model(s) facilitates linkages among agencies within and external to the primary health care system in order to work collectively to improve the health of a population.

29. The governance model(s) demonstrates alignment with the goals and objectives of the respective DHA or the IWK Health Centre.

30. Government's role is to provide system leadership, funding, broad standards setting, evaluation, and protection of the public interest.

Accountabilities

31. Accountabilities within relationships are clearly defined for the following:
    - Department of Health and other relevant departments/sectors
    - District Health Authorities and the IWK
    - Community Health Boards
    - Community-based organizations
    - Primary health care organizations
    - Academic partners
    - Private sector partners
    - Third Party Payers
    - Providers, professional associations and other contributors
    - Individuals, families, and communities

32. There is a commitment to effective and innovative public consultation, public communication, community mobilization and participation, and functional integration in planning, health promotion, and primary health care service delivery.

33. Individuals, families, and communities have information about their health needs and the goals of primary health care provided in a way that they can understand and use. This information will support their decisions and assist them in setting priorities to maintain and improve their health status.

34. Consumers and providers are given information on the benefits and costs of services.

35. Performance and outcome standards are used to support informed, evidence-based decision making.

36. Adequate resources are in place to measure outcomes and to provide appropriate incentives to renew the primary health care system and improve the health status of Nova Scotians.

37. The primary health care system is evaluated on an ongoing basis related to meeting community needs, efficiency and effectiveness, financial accountability, and standards of care and service.

38. Human resources planning and development takes place in a coordinated fashion among government, districts, organizations, communities, health professionals, the academic sector, and others.

39. Planning and service delivery demonstrate commitment to valuing and responding to the diversity and uniqueness of individuals and communities.

Funding

40. Funding promotes the most appropriate match of dollars to community primary health care needs, including financial incentives for targeted health promotion and disease prevention outcomes.

41. Funding provides incentives for increased access based on individual and comprehensive community characteristics, including but not limited to age, gender, race, socio-economic status, geography (rural isolation), and language barriers.

42. Funding is flexible enough to recognize and maximize existing community assets (i.e. community fund-raising, volunteers, corporate resources in the community, employers, hospital or health foundations and auxiliaries, etc.) and allow for community level fund-raising and accessing non-traditional funding sources.

43. The funding approach accounts for fixed and capital costs of running a primary health care organization (e.g. IT costs, administration support, heat, lights, rents, etc.).

44. Funding is adjustable for disease prevalence that typically places a high demand on the primary health care system.

45. Funding is responsive to the determinants of health, to the extent possible.

46. Any cost savings in one part of the health system as a result of good primary health care should be reinvested to other parts of the primary health care system that require further supports.

47. Funding for primary health care is non-portable.

48. The funding approach includes funding for a variety of professions such as pharmacists, physiotherapists, and social workers, based on the characteristics of the population served. Funding is also be provided where appropriate for children's day care, eldercare, transportation, etc.

49. Blended funding (alternative funding plus fee-for-service) is available in situations where particular services or interventions need to be encouraged.

50. The funding approach recognizes and builds on current successful services and programs.

51. The funding approach includes the initial recruiting costs for new providers, contributors and positions.

SECTION THREE

CENTRAL COMPONENTS OF THE PRIMARY HEALTH CARE SYSTEM

Services and Programs

Key Messages

Primary health care services and programs should

- Address the interaction of the determinants of health and contribute to the continuum of primary health care
- Be delivered in a collaborative manner at times and locations that are flexible and accessible for individuals and communities
- Foster cooperation among communities and allow communities with different capacities the opportunity to meet their needs
- Provide entry points to a comprehensive, seamless system that promotes continuity of care
- Be sustainable and based on evidence and best-practice

What are Services and Programs?

The terms "programs" and "services" are often used interchangeably in discussions related to health service planning and delivery. Typically, however, a service in the health system refers to a particular type of activity provided to or in support of someone with the intent of promoting health or preventing, diagnosing, or treating that individual's illness.

Services may often be organized into programs according to various criteria, such as population served (e.g., services for women), geographic location (e.g., services offered in the North End of Halifax), or health concern/diagnosis (e.g., services which focus on diabetes). Service delivery organizations may keep programs distinctly separate so that each is identifiable in terms of staff, resources, clients, and services provided. A program, then, may appear to have a more formal structure that includes elements of administration and multiple services aimed at achieving a defined goal.

The way services and programs are structured and offered varies among communities, providers, and sectors. Regardless of whether a person seeks to access a "service" or a "program," a primary health care system needs to be engaged in activities that meet the needs of a community.

Current Situation

Nova Scotia has been engaged in a wide variety of primary health care activities for a long time. From initial and ongoing primary care to mental health and addiction services, there are numerous examples of how Nova Scotia communities have responded to the primary health needs of their populations. Some of these include

Initial and Ongoing Primary Care

Family physicians have been significant contributors to the primary health care system over the years providing health promotion and disease prevention, acute episodic care, continuing care of chronic conditions, and education and advocacy to individuals and communities. Another setting for initial and ongoing primary care is the community health centre (CHC). Some CHCs in Nova Scotia offer strictly medical services while others offer treatment, prevention, and promotion services. Many provide a broader range of services in primary health care such as well women's clinics, physical activity programs, literacy services, and environmental services such as annual community clean ups. The role of the four Strengthening Primary Care Initiative demonstration sites has also evolved from primary care to include primary health activities such as sex education and counseling at local high schools, flu clinics, weight control programs, public information days, and foot clinics (Nova Scotia Department of Health, 2002).

Public Health Services

Public Health Services are focused on improving the health of the population by working in partnership with communities, families, and individuals to identify health needs and health potential as well as by supporting collective and individual action to prevent illness, protect and promote health, and achieve well-being. Public Health provides population health assessments, health surveillance, population health advocacy, health promotion, disease/injury prevention, and health protection services. Examples of these services and activities include monitoring and protection from communicable and non-communicable diseases, the delivery of anti-smoking programs, child health and developmental screening, health counseling for youth, administration of immunizations, and education and support for new parents.

Emergency Health Services

The core service delivery components of Emergency Health Services (EHS) in Nova Scotia include a communications centre, ground ambulance, Air Medical Transport Program (EHS LifeFlight), and the Trauma Program. One example of an innovative way in which EHS is helping to meet community needs is the Excess Capacity Project. Through this initiative, paramedics are stationed on Long and Brier Islands and function in an expanded role providing public education, injury prevention activities, non-emergency clinical care, as well as collaborative activities with family physicians, a nurse practitioner, and Public Health and Home Care.

Mental Health Services Program

In recent years, Nova Scotia's mental health services program has increased emphasis on consumer-centered service and community mental health programming, as well as a strong focus on housing and population health issues. These principles form the underpinning of all new mental health program and policy development. Core components of Nova Scotia's mental health service program include promotion, advocacy, education, and prevention; adult outpatient and outreach; adult inpatient; adult rehabilitation (community supports); specialty programs; and child and youth services.

Some examples of the unique ways in which services are being delivered include Shared Care and the Connections Clubhouse. In Shared Care projects, mental health clinicians work collaboratively with family physicians in group practice to provide mental health services to patients in the practice requiring such service. The Connections Clubhouse Program is an innovative community-focused model of psychosocial rehabilitation and integration for the chronically mentally ill.

Continuing Care

Continuing Care includes the integration of long-term care, home care, and adult protection services. Continuing Care works collaboratively with Community Services in the delivery of community-based options; local branches of VON Canada in the delivery of home care services; and the RCMP, municipal police, and EHS in the delivery of adult protection services. They also network with community and volunteer resources to link clients with resources when needed. The Single Entry Access (SEA) Project has been developed which provides a single point of entry for individuals to access continuing care services.

Addiction Services

Addiction Services are aimed at addressing the physical, social, spiritual, and economic well-being of their clients. The services have a holistic approach to prevention and treatment of alcohol, drug, and gambling addictions. Clients include the addicted individual, their families, and others impacted by the addiction (e.g. coworkers). Services are community-based, offered locally, and, for the most part, are accessible by self-referral.

Core components of Addiction Services include prevention and community education, community-based drug dependency treatment services, regional drug dependency treatment services, and targeted drug dependency services (such as adolescent treatment, services for women, and impaired driving offenders).

One example of an innovation in the delivery of primary health addiction services is the Community Based Demonstration Project. In this project, addictions staff worked with four junior high schools, collaborating with school administration, parent teacher associations, Dalhousie University, and students of the schools. Prevention programs were offered to students who don't use drugs, and harm reduction programs were offered for students who use drugs, with emphasis on identifying and treating students with addiction problems.

Local Community Initiatives

Nova Scotia communities recognize the importance of meeting the primary health needs of their population by providing well integrated and coordinated services. Following are just a few examples of local inititiatives that some Nova Scotia communities have undertaken that shape the services and programs available in their communities.

The Halifax Inner City Initiative has developed a process to address the social, environmental, and economic concerns of the inner city community with the aim of reducing poverty. Using a collaborative process that involves the community, government, and the private sector, the initiative has undertaken a number of projects targeted to the entire age spectrum (the early years to seniors) addressing employability, health, and social justice issues.

The Healthy Parrsboro & Area Committee utilized a community development approach to conduct a community needs assessment and received funding from the Task Force on Primary Health Care to act on the findings of that needs assessment. Some 10 years later, the Healthy Parrsboro and Area volunteer initiative continues to support community-driven initiatives such as promoting and supporting self-help groups, partnering to develop community youth activities, and providing supports to seniors.

The Medical Emergency Digby in Crisis (MEDIC) is a community-based group whose mandate was initially to secure emergency services in the Digby area. The group has evolved and broadened its mandate to include the development and implementation of a responsive, integrated, community-based primary health care system in their community.

Rationale for Change

Many excellent primary health care services exist in Nova Scotia, provided by dedicated physicians and nurses and many other health providers. Many communities are working hard to meet the primary health care needs of their residents. However, although numerous primary health care services and activities exist within Nova Scotia's health care system, we need to build on these to ensure that services and programs are integrated, and not offered in isolation. While the province celebrates many innovations in service delivery, we need to ensure that all Nova Scotians have access to a comprehensive range of primary health care services that proactively address the determinants of health and promotes wellness and continuity of care.

Options for Primary Health Care Services and Programs

The first step in developing a consistent approach to primary health care delivery in Nova Scotia is to identify a consistent manner of categorizing and organizing primary health care services. Both the literature and experience confirm that there are many ways to name or categorize services and programs. Some of these methods include categorization by, for example

- program area (e.g., long-term care, primary medical care, etc)
- provider (e.g., nutrition services, physician services, nursing services)
- strategy (e.g., prevention, promotion, rehabilitation, etc)
- life-stage (e.g., maternal and child health, teen

health, seniors health)

- health issue (e.g., diabetes, heart disease, AIDS)

It is also not uncommon to see combinations of these categories when defining the spectrum of primary health care services. For instance

Basic Emergency Services
Communicable Disease Prevention and Control
Community Mental Health Services
Community Supports
Continuing Care (Home Care, Long Term Care, Small Options Homes, Palliative Care, etc.)
Dental Health Services
Environmental Health Services
Health Promotion (including community development)
Healthy Child Development
Nutrition Services
Primary Maternity Care
Prevention & Treatment of Common Diseases and Injuries
Rehabilitation Services
Sexual Health and Family Planning Services
Other publicly funded services (services such as housing, income assistance, occupational health & safety, and education programs that are delivered by other government departments)

Detailed definitions of each of these services can be found in Appendix Four.

Recommendations

Criteria for Primary Health Care Services and Programs

Building on the vision for primary health care, the ACPHCR recommends that primary health care system and service delivery organizations work toward delivering services and programs that meet the following criteria:

1. Services and programs proactively address the interaction of the determinants of health.
2. Services and programs contribute to the continuum of primary health care.
3. Services and programs are delivered in a collaborative manner.
4. Services and programs are sustainable.
5. Services and programs are based on available evidence and best practices.
6. Services and programs are provided in a manner and at times and locations that are flexible and accessible for individuals and communities.
7. Services and programs foster cooperation among communities, and are established in a way that allows communities with different capacities the opportunity to meet their needs.
8. Services and programs provide entry points to a comprehensive, seamless system that promotes continuity of care.

Other Recommendations

The ACPHCR recommends that the following list of services should, over time, become the foundation of the primary health care system:

1. Basic Emergency Services
2. Communicable Disease Prevention and Control
3. Community Mental Health Services
4. Community Supports
5. Continuing Care (Home Care, Long Term Care, Small Options Homes, Palliative Care, etc.)
6. Dental Health Services
7. Environmental Health Services
8. Health Promotion (including community development)
9. Healthy Child Development
10. Nutrition Services
11. Primary Maternity Care
12. Prevention & Treatment of Common Diseases and Injuries

13. Rehabilitation Services
14. Sexual Health and Family Planning Services
15. Other publicly funded services (services such as housing, income assistance, occupational health & safety, and education programs that are delivered by other government departments)

Other planning considerations for primary health care services include the following:

- While not every community in Nova Scotia will or should have the same level of access to each of these services, some degree of each of these categories of services should be either directly provided or arranged for in every community in Nova Scotia.

Family caregivers should be involved in policy development and named in policies that affect them. Their needs should be assessed, and a range of supports should be available to them.

- Communities and District Health Authorities should work together using a population health approach to identify the mix of services that is needed, where they should be located, and how they can be accessed.
- Teen health services should be acknowledged to be a key component that is woven throughout the various recommended services. The teen years are very important in shaping behaviors that will impact on the long-term health status of that population.
- These services should be delivered in an integrated manner, with a team- and family-centered approach, using case management and/or navigation among and between services.
- Planners and policy makers at the community, district, and provincial level should use this recommended list of services to prioritize and make decisions about what primary health care services should be publicly funded today and in the future.

Contributors

Key Messages

- The preferred future for primary health care providers is the interdisciplinary collaborative team, where the core team includes the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider, and midwife.
- The way teams are organized and accessed should reflect the needs of the population and will therefore be different in different communities
- The primary health care system should support both family physicians and midwives in the delivery of collaborative team based primary maternity care.
- Family caregivers should be involved in policy development and named in policies that affect them. Their needs should be assessed, and a range of supports (i.e. financial, replacement care) should be available to them.
- More work must be conducted related to the possible relationship of providers of complementary and alternative health care to the primary health care team.

Who are Primary Health Care Contributors?

The primary health care system is broad and encompasses the strengths, innovations, and leadership of individuals, communities, populations, and multiple sectors within Nova Scotia. Within this system are a variety of public and private sector health professionals who provide care to individuals and communities. These are typically referred to as "providers."

There are also a host of other individuals who are not health professionals but who also contribute to the health of individuals and communities. These include volunteers, family caregivers, neighbors, and friends. There are also a variety of professionals who work in other sectors whose work contributes to the health of the population (i.e., teachers, occupational health and safety officers in private industry, and community recreation coordinators). Of course, the individual contributes to his or her health as well. The term "contributors" is used to name those health care professionals and other persons whose work contributes to the health of individuals and communities.

In considering contributors, the ACPHCR did not conduct an in-depth health human resources planning analysis in an attempt to determine the specific role and required supply for each contributor. Rather, it based these recommendations on the work of the Task Team on New and Existing Primary Health Care Providers, which considered the major issues facing contributors today, and possible ways of addressing these issues including a focus on increasing collaboration among contributors.

Current Contributors in Nova Scotia

Primary Health Care Providers

There are a wide variety of public- and private-sector health professionals who provide care to individuals and communities. They include, for example, family physicians, family practice nurses, public health nurses, nurse practitioners, pharmacists, nutritionists, physiotherapists, occupational therapists, and social workers.

Many providers have and will continue to play a key role in the delivery of primary health care in Nova Scotia. For example, for many years family physicians have been the first point of contact for individuals who need primary medical care.

A caregiver is "a family member, friend or neighbour who provides support and care to family or friends who are physically or mentally challenged, chronically ill or frail and elderly either at home or in a care facility. Family caregivers provide care to all age groups, regardless of the care receiver's disease or disorder as well as palliative situations. Caregivers are spouses, children of all ages or in-laws, siblings, children, and other extended family members or friends. Caregivers have a special relationship with their care receivers" (Family Caregivers Association of Nova Scotia, 2001). Caregivers provide unpaid care and/or support and are distinguished from volunteers through their personal bond or connection to the care recipient (Family Caregivers Network Society, 2001).

Likewise, public health professionals across the province have worked for many years to promote health and prevent disease and injury. They have and will continue to play a key role in the delivery of primary health care services in Nova Scotia.

Some providers work largely independently of others. For instance, family physicians in Nova Scotia work mostly in solo or group practices without formal or informal mechanisms for coordinating or integrating their work with other components of the primary health care system such as public health, mental health, addictions, and others.

Others are supported by either formal or informal mechanisms that support varying degrees of interaction. For instance, public health services are delivered by an interdisciplinary team that includes public health nurses, health educators, dental hygienists, nutritionists, support staff, medical officers of health, epidemiologists, and administrators/managers working at the provincial, district, and community levels of the province's health system. Public health's philosophy for improving the health of the population is to partner with communities, families, and individuals.

Over the past four years, four Nova Scotia communities have taken steps toward developing a team approach to delivering services. The Strengthening Primary Care Initiative is a model for the development of collaborative practice between family physicians and nurse practitioners in Nova Scotia. This working relationship is formalized through a Collaborative Practice Agreement that outlines the authority, roles, accountabilities, and liabilities of each, the principles of the practice, and the authorized practice of the nurse practitioner. Since the fall of 2002, nine additional communities have begun to move in this direction.

While multi and/or interdisciplinary team models of primary health care service delivery are not necessarily the norm in Nova Scotia, examples do exist. Of the nine community health centres in Nova Scotia that are members of the Nova Scotia Federation of Community Health Centres, most are characterized by having more than one provider. Some involve a variety of providers and employ a "team" approach to providing care. The North End Community Health Centre is one such example. This team includes family physician, psychiatric consultant and resident, family practice nurse, dietitian, social worker, nurse practitioner, mental health worker, and lactation consultant working together to meet the needs of a defined population.

Providers of Primary Maternity Care

Although a wide range of providers may be involved in providing services along the continuum of primary maternity care (see Appendix Five for a definition of primary maternity care), family physicians have historically been the main providers of primary maternity care in Nova Scotia. Between 1988 and 2000, however, the number of family physicians in Nova Scotia who attended births decreased from 550 to 250. The volume of visits and deliveries provided by family physicians and general practitioners also decreased during this period (Attenborough, 2002). The declining number of family physicians and the lack of other providers of primary maternity care in Nova Scotia has resulted in obstetricians taking an increased role in the provision of primary maternity care services in Nova Scotia.

Nurse practitioners are relatively new primary health care providers who provide pre- and post-natal care in Nova Scotia. Public Health Services has, however, played a major role in providing services from preconception to childbirth and postpartum for many years. While variations in these services exist, they are guided by Public Health targets and standards. Some of the services provided include prenatal education and counseling, telephone and/or home visits, the Healthy Baby Program, telephone support lines, well baby clinics, breastfeeding and parenting support groups, referral to other community resources, and enhanced home visiting. Public Health Services has, however, experienced a reduction in human resources over the last 10 years. This has affected the type and level of primary maternity care services and programs offered.

Many prenatal and postnatal support services are also provided at the community level. Family Resource Centres, and in particular those with Health Canada funded Canada Prenatal Nutrition Programs, are good examples of models of community-based prenatal and postnatal support services.

The IWK Health Centre also plays a key role in the delivery of primary maternity care services in Nova Scotia. Up to 80 per cent of births at the IWK Health Centre are considered primary maternity care. The academic tertiary setting, however, often results in interventions that are not necessarily congruent with the philosophies of primary maternity care (Hawley, 2002).

The Family Caregivers Association of Nova Scotia estimates that there are more than 86,000 family caregivers in Nova Scotia.

Midwives are trained specialists who care for women throughout pregnancy and childbirth. Despite the fact that two previous government-commissioned reports (1997 and 1999) recommended the regulation and integration of midwives as a provider of primary maternity care in Nova Scotia, the necessary conditions have not yet been established to enable this to happen. There are many regulatory/licensing options that would support the introduction of midwives in Nova Scotia without full-scale legislation and self-regulation as in the establishment of a professional college. These include direct regulation by government, regulation under a program of the department, establishment of a transitional regulatory body, omnibus legislation, and ministerial authority.

Family Caregivers

In 2002, the Canadian Caregiver Coalition estimated that family caregivers save the health care system over $5 billion per year and that the work they provide is equivalent to more than 276,000 full-time employees. The Family Caregivers Association of Nova Scotia estimates that there are more than 86,000 family caregivers in Nova Scotia.

Caregivers may experience significant negative consequences to their health and well- being due to the demands of caregiving. The emotional, financial, information and education, and replacement care needs of Nova Scotia's caregivers, however, are not being assessed. Financial benefits to family caregivers are currently limited to a tax credit, but only when the care recipient's income is less that $15,453.00 (Canada Customs and Revenue Agency, 2001).

The Department of Health homecare policy provides for 10 hours per week (or 40 hours per month) of replacement care for those caregivers who qualify. However, the provision of this service is dependent upon whether or not the human resources and respite bed are available when the service is required as well as the result of a comprehensive financial assessment. The information, education, and emotional supports that are required by caregivers today are not uniformly available throughout Nova Scotia.

Complementary and Alternative Health Care Providers

It is difficult to name all those providers of complementary and alternative medicine (CAM) because the list of what is considered to be CAM changes continually as those therapies that are proven safe and effective become adopted into conventional health care (National Centre for Complementary and Alternative Medicine, 2002).

Statistics Canada and Health Canada report varying levels of CAM utilization. However, the literature indicates that increasing utilization of CAM modalities has been led by consumer demand versus evidence of the effectiveness of treatment (Zollman & Vickers, 1999).

Few CAM providers are regulated in Canada and most have no professional association. Regulation is inconsistent across the country. The effectiveness of CAM interventions is not often supported by evidence. The literature suggests, however, that consumers have little concern about the professional regulation of CAM providers (Casey & Picherak, 2001). There are also certain risks associated with some CAM therapies, and the primary health care provider may assist the client in making choices based on the known risks and available information. This is complicated, however, by the fact that not all clients inform their primary health care provider that they are receiving CAM treatment. Clients also may not inform their CAM provider of the medical treatment they are receiving.

Rationale for Change

A national trend toward "team" delivery of primary care is emerging. The Kirby Report indicates that the six major primary health care reform reports recently conducted by various Canadian jurisdictions "advocated the delivery of comprehensive primary care through some form of multi-disciplinary team." (Kirby Report, 2002, p. 81). Most recently, the Romanow report has also recommended that primary health care should be supported by interdisciplinary teams or networks of primary health care providers. He recognizes that the "multiplicity of health care providers is both a tremendous resource and a challenge in terms of sorting out new models of primary health care, new roles and responsibilities, and more collaborative ways of working together" (p. 103). However, the Romanow Report is clearly committed to the concept of teams and networks of providers in the primary health care system of the future.

While not the only factor that affects an individual's or community's health, contributors are in a unique position to do so. Their continuing relationship with the client and community provides opportunities to educate, treat, and advocate. In Nova Scotia, it is time to build on the strong foundation that has been formed by family physicians. It is time to create new ways for existing and even new contributors to increase their impact by working together toward a goal of improved health for Nova Scotians.

Options for Contributors in Primary Health Care

The Task Team on Existing and New Primary Health Care Providers identified similarities between the possible degrees of collaboration and the possible degrees of integration that the System Design Task Team had developed. They then adapted this concept to primary health care contributors. In this context, the possible degrees of collaboration between primary health care providers include

- communication
- consultation
- cooperation
- coordination
- collaboration
- collaborative practice

Table One, on the following page, defines each of these degrees of collaboration. Each degree of collaboration includes those that precede it, and each is appropriate for different situations depending on the goal of the relationship. For example, a solo-practice family physician is not responsible to collaborate with any other provider. However, in the interest of the client, he or she communicates or cooperates with other contributors as needed. Members of a public health team that is responsible for a certain region or territory each know their roles and authorities, and they are also a direct resource (i.e., for referral) to the other team members.

In a formal collaborative practice relationship, a Collaborative Practice Agreement outlines the authority, roles, accountabilities, and liabilities of each team member, as well as the principles and scope of the practice.

TABLE ONE

Possible Degrees of Collaboration

COMMUNICATION

Ad hoc or planned sharing of information.

CONSULTATION

Communication in which one party seeks advice or direction from the other.

COOPERATION

A short-term informal relationship that exists without clearly defined mission statements, structures, or plans. Providers who cooperate retain their individual authority, and resources remain separate. (adapted from Winer and Ray, 1997)

COORDINATION

A more formal relationship that has a shared mission and more formal structural and planning arrangements. Providers who coordinate retain their individual professional authority, but share resources to advance their mission. (adapted from Winer and Ray, 1997)

COLLABORATION

A process in which those parties with a stake in the problem actively seek a mutually determined solution. Collaboration may be motivated by a desire to advance a shared vision or a need to resolve conflict. The expected outcome of collaboration may be the exchange of information or the development of a joint agreement. Providers who collaborate form new structures to address their mission. Such relationships involve detailed planning and communication as well as the pooling of resources. (adapted from Gray, 1989, 1996)

Is a strategy for building relationships and doing work. (Winer and Ray, 1987)

COLLABORATIVE PRACTICE

A highly structured form of continuing collaboration among members of an interdisciplinary team for communication and decision making that enables the separate and shared knowledge and skills of care providers to synergistically influence the client/patient care provided. (Adapted from Daniel Way, Linda Jones and Nick Busing, 2000).

A specific type of collaborative practice in Nova Scotia is collaborative practice between physicians and nurse practitioners as required by the College of Registered Nurses of Nova Scotia.

Partnerships are a form of collaboration. The characteristics of partnerships includes

- shared authority, responsibility, and management
- joint investment of resources
- development of new structure
- comprehensive planning
- detailed communication strategies
- distribution of power: may be unequal
- shared liability, risk taking, accountability, and rewards

Each degree along the continuum is inclusive of those that precede it.

Recommendations

Criteria for Contributors

Building on the vision for primary health care, and based on the information presented about providers and contributors to primary health care, the ACPHCR recommends that the primary health care system and models of community-based service delivery work toward meeting the following criteria:

1. Providers and contributors work as a team.
2. Primary health care delivery involves health care providers and other contributors that reflect and are responsive to the needs of the community.
3. Collaboration or partnerships among providers and/or the community, whether formal or informal, are supported and/or enabled by one or more mechanisms which may include collaborative practice agreements, health promotion networks, intersectoral continuing education programs, networks and contractual agreements, team meetings, administrative coordination and support, and other supports and linkages.
4. In order to ensure quality and continued contribution, providers and contributors are supported by
   a. flexible and alternative arrangements and mechanisms such as alternative payment options and flexible working hours that address lifestyle issues and are responsive to community needs
   b. ongoing education and resources that support primary health care providers in both their delivery of services and in collaborating with others
5. The role of contributors and the role and scope of practice of providers are developed collaboratively and are clearly defined in the context of service delivery.
6. Training of new primary health care providers reflects the desired models of primary health care.

Other Recommendations

Following are a number of key recommendations aimed at increasing collaboration among a variety of primary health care providers. The actual implementation of these ideas would result in a real impact on the health of Nova Scotians and a fundamental change in the way that providers work together. The capacity to monitor and evaluate the impact of these changes will be key to informing future activities as we move forward with voluntary incremental improvements to the community-based primary health care system in Nova Scotia.

Primary Health Care Providers

1. The preferred future with respect to primary health care providers within primary health care service delivery organizations is the interdisciplinary collaborative team where the interdisciplinary collaborative team is made up of core and extended providers
   a. Core providers are those with whom the client has a longer-term and continuing relationship. Extended providers are those with whom the client has shorter-term relationships at times when the client requires a specialized service.
   b. In the renewed community-based primary health care system, this core team would include the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider(s), and midwife.
   c. The structure of the core and extended team will reflect the needs of the population being served. However, it is recognized that other factors such as geography will also affect the structure of a team. As a result, teams will look different in different communities. Communities and primary health care service delivery organizations may combine or coordinate their resources to ensure access to team members.
   d. At the individual client (versus population) level, the team will consist of different providers at different times and for different situations.

2. The Department of Health, DHAs, and providers should consider the remaining recommendations of the task team that relate to the interdisciplinary primary health care team as they shape and develop teams in the future. These recommendations can be found in Appendix Six.

3. The Department of Health should conduct further work related to possibilities for enhanced or new roles for providers (such as paramedics, dietitians, pharmacists, social workers) who have not yet been part of an interdisciplinary team. This work should consider roles, funding, information systems, and education.

The Department of Health, DHAs and relevant organizations should work together to develop collaborative team-based models for the delivery of primary maternity care that take into account the needs and resources of individuals and the community.

Providers of Primary Maternity Care

4. The primary health care system should support a collaborative team-based approach to the delivery of primary maternity care with the participation of family physicians and midwives at their full scope of practice.

   a. The Department of Health should immediately establish a regulatory/licensing mechanism for midwives.

   b. The Department of Health, DHAs and relevant organizations (e.g., IWK Health Centre, the Reproductive Care Program, professional groups) should work together to develop collaborative team-based models for the delivery of primary maternity care that take into account the needs and resources of individuals and the community.

   c. The Department of Health should work with DHAs to develop settings for the delivery of primary maternity care services that are specifically designed to support the philosophy and practice of primary maternity care and include midwives.

   d. Academic institutions, in consultation with the DHAs, Department of Health, and relevant professional groups, should develop educational experiences that reflect this collaborative team-based approach to the delivery of primary maternity care.

Family Caregivers

5. The Continuing Care Branch should name and involve caregivers in relevant policies, adopt and implement a standard protocol for assessing the needs of the primary caregiver, and work with various public and private organizations and agencies to develop a variety of forms of financial, emotional, information and education, and replacement care supports for family caregivers.

Providers of Complementary and Alternative Health Care

6. The Department of Health should conduct further work related to the possible relationship of complementary and alternative health care providers to the primary health care team. This should include consideration of issues such as access to quality information about CAM therapies, education of primary health care providers and the public, the use of CAM by certain culturally identifiable groups, possible institutional policies for CAM, and the future licensing and regulation of CAM providers in Nova Scotia.

Integration and Linkages

Key Messages

The primary health care system and service delivery organizations should:

- **Establish planned linkages, networks, strategies and functional integration among government departments, non-governmental organizations, communities, the academic sector, First Nations and with other levels of care**
- **Share information and resources that contribute to individual and population health**
- **Develop for individuals, confidential and common health records that include basic health history and current health status that, with the individual's agreement, can be shared**
- **Provide a mechanism(s) to assist individuals and families in navigating through the health care system and the broad range of community supports and services.**

What Are Integration and Linkages?

"The purpose of integrated care is to use resources to the best effect to improve the health of a population through planning and organizing care and community actions in an integrated way" (Ovretveit, 1999, p. 12).

Definitions and models of integrated health care focus on the coordination of health services across the continuum of care, as well as the collaboration among providers and provider organizations in the delivery of health services.

In the context of primary health care, there are two main dimensions of integration to consider. First, is the linkage and integration of diverse programs and services within the primary health care system (including other sectors). Second, is the linkage and integration between the primary health care system and other levels of health care such as secondary and tertiary care.

Shortell (1994, as cited in Richardson et al, 1998) defines integration as "the extent to which functions and activities are appropriately coordinated." If integration is the extent to which functions and activities are coordinated, then there are varying degrees of integration from very informal to highly formal. These include

- communication
- cooperation
- coordination
- collaboration
- formal integration

Table Two, on the following page, shows these possible degrees of linkages and integration, and their relationship to one another.

TABLE TWO

Possible Degrees of Linkage and Integration

COMMUNICATION

Ad hoc or planned sharing of information.

COOPERATION

Short-term informal relationships.

No clearly defined joint mission statements, structures, or plans.

Participants retain authority, separate resources.
(Winer & Ray, 1997)

COORDINATION

More formal relationships.
Shared missions.
Formal structural & planning arrangements.
Participants retain authority but share resources to advance mission.
(Winer & Ray, 1997)

COLLABORATION

Process in which parties actively seek a mutually determined solution.

Motivated by desire to advance a shared vision or a need to resolve conflict.

Detailed planning, communication, pooling of resources.

Expected outcomes: joint agreements, managing bodies created to address agreements, new structures to address mission, partnerships.

Partnership characteristics:
-shared authority, responsibility, and management
-joint investment of resources
-development of new structure
-comprehensive planning
-detailed communication strategies
-distribution of power may be unequal
-shared liability, risk-taking, accountability, and rewards.
(Gray, 1989, 1996).

FORMAL INTEGRATION

Brings together all primary health care service delivery categories under one organizational structure, which itself would be formally linked or integrated with the broader health system.

Note: Each degree of linkage and integration along the continuum is inclusive of those that precede it.

These degrees of linkage and integration are adapted from Winer & Ray (1997) and Gray (1996). Each successive type of linkage includes and incorporates those that precede it. As we move along this spectrum, the relationship between organizations changes and the extent of integration increases. Because not all relationships are formal, we also refer to the term "linkages," which reflects the more informal degrees of integration.

- Some Community Health Centres provide outreach to schools through breakfast programs and teen health centres, literacy programs to schools and families, physical activity programs, health education, and support services such as income tax preparation and job search assistance.
- Emergency Health Services collaborates with fire and police departments and schools to deliver various education programs, and with a family physician and nurse practitioner in the Long and Brier Islands area to provide basic primary health care services.

Emergency Health Services collaborates with fire and police departments and schools to deliver various education programs...

Integration and Linkages in Nova Scotia's Primary Health Care System

Current Situation

There are many examples of the more informal types of integration (i.e., communication, cooperation, coordination, and collaboration) taking place in Nova Scotia today. Examples of these, as identified by the Department of Health in a 2002 review of primary health care services, include the following:

- Family physicians collaborate with homecare and palliative care services to provide continuity of care for a recently discharged elderly patient, or working with Community Services and mental health service regarding a child born to a mother with hepatitis C and a previous history of addictions.
- Mental Health and Community Services collaborate for adult mental health programs. There are also strong linkages with the education system in the delivery of mental health services to children and youth in the school system.
- The Departments of Health, Education and Culture, Community Services, and Justice collaborate extensively on child and youth service delivery.
- Continuing Care collaborates with the Department of Community Services in the delivery of services in community-based options. They also network with community and volunteer resources to link clients with needed resources such as RN, LPN and Homemaker services. Continuing Care also collaborates with the RCMP, municipal police and EHS in the delivery of adult protection services.

- There is a strong collaborative relationship between public health and the education system in the delivery of services. For example, public health provides immunizations and associated education, curriculum support on issues related to specific health topics, and delivers and coordinates the fluoride mouth rinse program and other dental health education initiatives. Public health also collaborates with the departments of Agriculture, Environment and Labor, and Justice in the delivery of services for communicable diseases relating to food, water, air, and blood-borne pathogens, and with the Office of Health Promotion and municipal governments on the Physical Activity and Youth Strategy.
- Addictions Services collaborates with employers, unions, and Human Resource Development Canada in assisting their clients to return to work, and to be supported in the work environment. They have formal linkages with the Department of Transportation for the Driving While Impaired Second Offenders Program, and they collaborate with the Department of Education in the delivery of adolescent treatment services and curriculum development.

Despite the above examples of informal integration and linkages, the primary health care system in Nova Scotia is not well coordinated.

- DHAs are currently responsible for integrating public health, mental health, addictions services, health promotion, disease prevention, diagnostic treatment, and acute care services. In the near future, DHAs will also include long-term care and home care services.
- Physician services are for the most part uncoordinated with the health care services offered by the DHAs.
- Many innovative primary health care initiatives underway outside the formal health system structure are not well integrated into the primary health care system. These include youth health centres, community-based action teams that implement, for example, heart health promotion initiatives at the community level, and programs that enhance the capacity of communities to take action on their identified health priorities.

Preferred Future

Based on the vision for primary health care, ideally the impact of increasing integration would be felt at the individual, community, provider, and primary health care system level. Table Three, on the following page, summarizes how we will know when Nova Scotia has achieved an integrated primary health care system from each of these perspectives.

TABLE THREE

The Preferred Future for Primary Health Care

We will know we have a primary health care system that is integrated when it is...

Community-based, family focused, and person centred:

PERSON	COMMUNITY	PROVIDER	SYSTEM
A person has an ongoing relationship with a primary care provider within the primary health care team. A person's cultural, racial, and spiritual experience is considered and responded to in the way services and supports are planned and received.	A community has a network of primary health care services that addresses its unique needs. Mechanisms are in place to allow everyone in the community to work together toward the same goal, to identify and build on strengths and capacities, and to define community health needs and best ways to meet them.	A primary health care provider has a trusted relationship with clients/patients based on honesty, mutual respect and responsibility, and the understanding that the client/patients comprehensive health care needs will be met through linkages to appropriate care and services.	The community development philosophy and approach are adopted as an integral part of the system. People in the community have information related to all the elements of the system (scope, providers, relationships, navigation, etc.) in a comprehensive, coordinated package.

Comprehensive:

PERSON	COMMUNITY	PROVIDER	SYSTEM
A person is contacted for an assessment that anticipates problems before they occur and is provided with education and skills to positively influence their health decisions.	A community has primary health care services with established linkages to community-based services and supports that address the determinants of health of its population.	Services and supports offered in the community are coordinated to offer a balance between promotion, prevention, primary curative services, rehabilitation, and community supports. Primary health care providers have established linkages to a broad range of community-based services that will address needs across the determinants of health.	All components of the primary health care system work together and are linked to the other parts of the health system (i.e., secondary, tertiary, acute care, continuing care, emergency care, etc.) to ensure that the community's health needs are met. All government departments consider and respond to health impacts in their legislation, policies, and practices. Formal linkages exist with other government departments that support primary health care and its focus on the determinants of health.

TABLE THREE (continued)

The Preferred Future for Primary Health Care

We will know we have a primary health care system that is integrated when it is...

	PERSON	PROVIDER	COMMUNITY	SYSTEM
Responsive and Flexible:	A person is assured that the providers and the system work together to respond to their unique and changing needs. A person has evidence that input or concerns raised have been considered and shared across relevant components of the system.	A community has a responsive system that coordinates and/or integrates a wide range of providers in the delivery of home, support, and social services. The community has a primary health care system that coordinates activities, programs, and services to reflect the culture and diversity of its people. The community has access to integrated information that assists in assessing needs and contributes to planning.	A primary health care provider refers clients/patients to other care when required believing that services should be provided by the health professional that best meets individual's needs. Providers refer clients/patients and communities to appropriate resources and supports to enhance individual and community health.	The system monitors and modifies its programs based on best practice and evidence. Individual, family, and community capacities are recognized and utilized in planning services and supports. The system provides access to and maintains integrated information.
Accessible:	In accessing care, including urgent care, a person knows that by accessing the system through one entry point he/she is linked to the whole health system. A person does not have to wait at one level of care because of incapacity at another level of care.	A community knows when, where, and how to access primary health care services and supports. A community has equitable, targeted, and coordinated programs and services for high-risk populations who have traditionally faced barriers in accessing care.	Providers of 24-hour urgent care have access to crucial information about all patients/clients within the population they serve. Providers have ready access to appropriate resources and supports to enhance individual and community health.	The system provides coordinated service for urgent care on a 24/7 basis as appropriate for community needs. The system supports access to appropriate care through entry points which are interconnected.

TABLE THREE (continued)

The Preferred Future for Primary Health Care

We will know we have a primary health care system that is integrated when it is...

Integrated, Collaborative, and Innovative:

PERSON	PROVIDER	COMMUNITY	SYSTEM
A person does not have to repeat his or her health history for each provider. A person does not have to undergo the same test multiple times for different providers. A person can make an appointment for a visit to a clinician, a diagnostic test, or a treatment with one contact. A person benefits from a coordinated approach to meeting complex needs of families, individuals, and communities as well as primary health needs such as housing, employment, literacy, etc., and receives help with making a more effective use of the network of community services.	A community has established linkages between providers and community-based services and supports to serve the needs of its population. A community is served by an organization that is innovative and reflects the community population-based approach to planning and programming. A community defines its needs, identifies its assets, and guides the use of resources to maximize service delivery and outcomes.	A primary health care provider can access electronic information about care delivered by another provider or at another site upon an individual's transfer from or referral to care. Primary health care providers work together collaboratively in interdisciplinary teams and are responsible for addressing all the health care needs of their population.	Information systems are developed to link consumers, providers, and payers across the continuum of care. The system is the medium for informing physicians that their patients have been hospitalized, have undergone diagnostic or treatment procedures; have been prescribed drugs by another physician; have not filled a previous prescription; or have been referred to a health agency for follow-up care.

TABLE THREE (continued)

The Preferred Future for Primary Health Care

We will know we have a primary health care system that is integrated when it is...

Accountable:

PERSON	PROVIDER	COMMUNITY	SYSTEM
A person's health goals and expectations are communicated.	A community's health plan, which reflects community needs and assets, is integrated with broader health system planning.	A primary health care provider is informed and assisted by timely health information and data and provides client/patients and community with information that facilitates their informed decision making.	Financial incentives and organizational structure are in place to align governance, management, and providers in support of achieved objectives. Information is provided on cost, quality, outcomes, and consumer satisfaction to multiple stakeholders – consumers, employees, staff, payers and purchasers, community groups, and external review bodies. A framework with reliable indicators is established to monitor the effects of health reform on access, quality, and affordability of health services. This information is then shared with relevant stakeholders.

Sustaintable:

PERSON	PROVIDER	COMMUNITY	SYSTEM
A person's continuous access to primary health care services is assured as service providers change.	A community has access to appropriate and coordinated services that are planned recognizing economies of scale with a view to minimizing gaps in service.	A provider is compensated in a manner that reflects creative, innovative, and effective approaches to the delivery of primary health care services. There is a supply of providers who are qualified and committed to working within a collaborative practice framework.	There is understanding of the impact of changes to one part of the system on the other.

(adapted from Leatt et al., 2000, and Pink et al, 1996)

Rationale for Change

In her discussion of health system integration, Leatt (2000) explains that health systems across Canada are fragmented and have led to increased consumer dissatisfaction and escalating costs. She also identified a number of reasons why quality of care and outcomes need to be improved. These may also be thought of as reasons why primary health care integration should change. They include

- gaps in care
- lack of coordination between primary care and specialty care
- lack of incentives to keep people well
- redundancies and duplication in the care process
- lack of incentives to ensure the right amount and quality of services are provided
- imbalance between professional autonomy and the common good of communities and individual consumers and patients

A well-coordinated, integrated, and sustainable primary health care system is needed to improve the health status of Nova Scotia's population.

There is also national recognition of the need for integration. The Romanow Report (p. 119) states "Providers and organizations are encouraged to integrate services from the first contact with a physician or nurse practitioner to services for people who are convalescing, have chronic illnesses, or who need acute or specialized services."

Options for Integration and Linkages in Primary Health Care

Possible Degrees of Integration

Each of the degrees of integration or linkage as identified in Table Two is an option. These include

- communication
- cooperation
- coordination
- collaboration
- formal integration

Each has its strengths and weaknesses and is, therefore, appropriate for different situations depending on what the goal of the relationship is. For instance, a fully integrated system requires one governance mechanism that is responsible for providers, services, funding, and so on. However, this degree of integration may not be required in all situations if the goal or desired outcome of the relationship is only to establish informal linkages.

Possible Mechanisms for Integration

A variety of mechanisms for integration are available. The chosen mechanism will depend on both the goal of the integration or linkage and the degree of integration or linkage that is best suited to achieving that goal.

... a fully integrated system requires one governance mechanism that is responsible for providers, services, funding, and so on.

Within the Primary Health Care System

Among services and programs, organizations, and providers within the primary health care system, examples of mechanisms of **communication** include newsletters, websites, and other communication tools, designated "provider only" phone lines and voice mail systems in community pharmacies and other key locations, correspondence between providers, and consumer health information systems.

If **cooperation** is the desired degree of integration, mechanisms such as joint continuing education events, short-term contacts between care providers, referrals (i.e., family physician referral for massage therapy), shared accommodations, and lease agreements may be used. Coordination may be achieved through, for example, Joint Executive Committees between disciplines and organizations, referral processes and protocols, intersectoral continuing education programs, health promotion networks, and ongoing community mapping of resources, supports, and inventories.

Examples of possible mechanisms to achieve **collaboration** include collaborative practice agreements, case management, interdisciplinary planning and service delivery teams, performance and reward systems for team accomplishments, electronic health record, networks and contractual agreements, affiliation or partnership agreements, and interprofessional education and training.

Mechanisms that may be used to achieve **formal integration** include governance, management, and funding models, legislated community development, merged government departments, and the integration of service delivery (i.e., DHA management of public health, addictions, tobacco control and mental health services).

With Other Levels of Health Care

A variety of mechanisms also exist to support linkages and/or integration between primary health care and other levels of care. For instance, at the **coordination** level, referrals and protocols may be used. **Collaboration** may be achieved through use of the telehealth network, shared care protocols, patient navigation, provincial programs, acute and chronic disease prevention, and control and management processes. Similar to integration within primary health care, example mechanisms to achieve **formal integration** with other levels of care include governance, management and funding models. To a certain extent we already see this through the DHAs who are responsible for acute care, and specific aspects of primary health care including public health, addictions, and nutrition services in their districts.

Recommendations

Criteria for Integration and Linkages

Building on the vision for primary health care, the ACPHCR recommends the primary health care system and service delivery organizations within that system work toward meeting the following criteria:

1. Opportunities for the development of planned linkages, networks, strategies, and functional integration exist among all sectors within primary health care (including governmental, non–governmental, community, academic sectors, and First Nations) and between primary health care and the secondary and tertiary health care systems.
2. Planned and organized sharing of information and resources that contribute to individual and population health takes place over time with the development of respect and trust among primary health care stakeholders and between primary health care and secondary and tertiary health care stakeholders.
3. Individuals have a confidential, common health record that includes a basic health history and current health status and may be accessed by their choice of providers with the individual's agreement.
4. Individuals and families are assisted in navigating through the health care system and the broad range of community supports and services.

Models of Primary Health Care Service Delivery

Key Messages

- **No single model of primary health care service delivery will meet the needs of all communities in Nova Scotia**
- **Communities must collaboratively develop primary health care service delivery models that best reflect their assets and meet their needs**
- **Participation in these models by providers and communities must be voluntary allowing gradual movement toward models that reflect the broader primary health care approach**
- **Support for change management must be provided**

Searching for "The" Model

Nova Scotia has not been alone in its quest for the ultimate model of primary health care service delivery, nor in its findings that there is no one best model to suit the needs of every community. In 1994, Abel and Hutchison stated, "The literature fails to point to an 'ideal' or 'most suitable' primary health care delivery model" (p. 64). Almost ten years later, the Romanow Report supports this notion and states, "The various obstacles (to primary health care) cannot be overcome through a single rigid approach. Given the diversity of communities and circumstances across the country, it makes good sense to take a flexible approach that can be adapted to different communities and different groups of people" (Romanow 2002, p. 119).

Evidence that supports this view now exists. The Canadian Health Services Research Foundation (CHSRF) is currently concluding work on an analysis of 28 primary health care delivery organizations from a variety of industrialized countries. The analysis involved both scientific and qualitative assessment. It concluded that no one organizational model is optimal and a combination of community-based and professional-based models is recommended.

After examining the various components of primary health care (i.e., governance, integration and linkages, accountability, services and programs, providers/contributors, and funding) and developing criteria for primary health care, the next question becomes "what model or models are 'best' for Nova Scotia?"

Part of the answer to this question lies in the criteria itself. The criteria presented in the previous section of this report outline a number of requirements that a service delivery organization should be working toward in order to become part of the renewed primary health care system. **Among these criteria is the clear and consistent identification of the need to respond to community need. Recognizing the unique strengths and capacities of each community, it would appear that no one model would meet the needs of all Nova Scotian communities.**

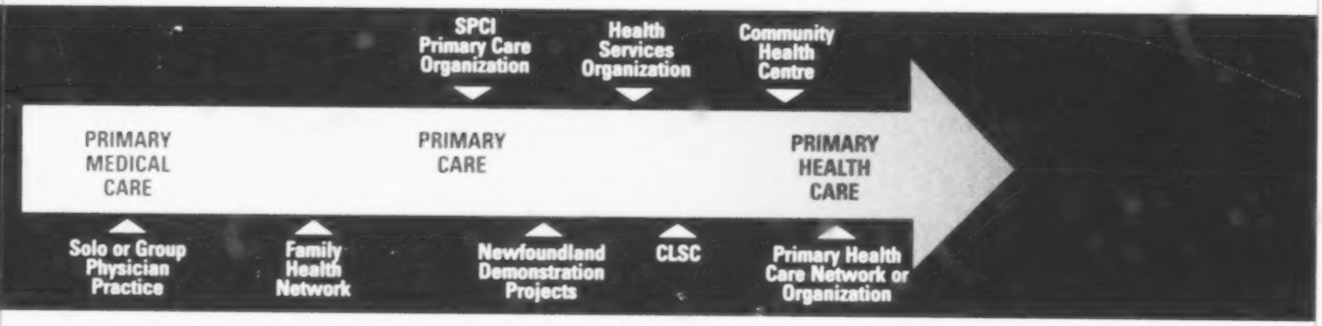
Current Situation

The research of the Task Team on System Design demonstrated that there is a wide range of models of service delivery organizations within Canada's and other international jurisdictions' primary health care systems. Examples of some of the more established models include health service organizations, community health centres, solo or group physician practices, and local community service centres (CLSCs). The SPCI primary care organizations and Newfoundland's Primary Health Care Enhancement Initiative sites are examples of models that evolved through demonstration projects. Family Health Networks are a very recent addition to the spectrum of models in Ontario.

It could be said that these models form a continuum from independent, individual providers whose focus is on primary care, to highly integrated organizations characterized by a team approach and a broad focus on primary health care. When depicted visually, this continuum

[illegible]

Diagram Two - A Continuum of Primary Health Care Service Delivery Models


SPCI Primary Care Organization
Health Services Organization
Community Health Centre
PRIMARY MEDICAL CARE
PRIMARY CARE
PRIMARY HEALTH CARE
Solo or Group Physician Practice
Family Health Network
Newfoundland Demonstration Projects
CLSC
Primary Health Care Network or Organization

Examples of Models

[illegible]

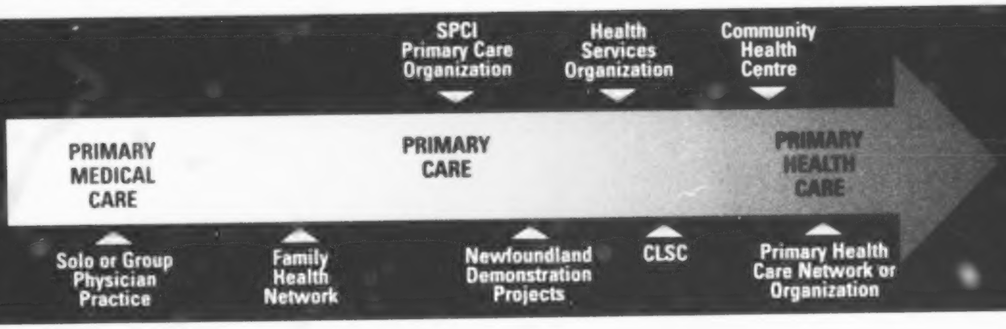
Ontario Family Health Network

[illegible]

[illegible]

might look like Diagram One. Progressing along the continuum, organizational models are in a better position to respond to the broad socio-economic determinants of health. Each model has its strengths and weaknesses in relation to Nova Scotia's vision and criteria for primary health care. The continuum demonstrates that characteristics of the models change as you move from primary care to a primary health care approach.

Diagram Two - A Continuum of Primary Health Care Service Delivery Models


SPCI Primary Care Organization
Health Services Organization
Community Health Centre
PRIMARY MEDICAL CARE
PRIMARY CARE
PRIMARY HEALTH CARE
Solo or Group Physician Practice
Family Health Network
Newfoundland Demonstration Projects
CLSC
Primary Health Care Network or Organization

Examples of Models

The models on this diagram do not necessarily represent the only ones in existence. There may be other models or variations that could also be found along this continuum. The ACPHCR assessed six of the models that are found on this continuum. Following are descriptions of selected models that, to varying degrees, meet the criteria for primary health care. The ACPHCR did not conduct a true quantitative "ranking" of the models, but rather compared the models to the criteria in a descriptive manner.

Ontario Family Health Network

Family Health Networks (FHN), which are specific to Ontario at the moment, are a very new model of primary health care service delivery. These organizations are local primary care networks with a minimum of four independent family physicians. Physician participation is voluntary.

The networks can be providers and/or organizations that are located in one physical setting or several settings. The core elements of this model include group practice; formal enrollment of clients; extended hours; shared call and integrated telephone health advisory service; emphasis on prevention; accessibility and comprehensiveness; information technology (electronic health records); and the delivery of core primary medical services (diagnostic, curative, preventative, primary mental health, counseling, and others). They are funded by a blended model that includes capitation, fee-for-service, and program funding. While its original intent included expanding to include other health care providers and specifically nurse practitioners, to date the involvement of either is limited.

FHNs do not exhibit many of the characteristics found within the criteria for governance, and integration and linkages. They do exhibit more of the desired accountability characteristics than some other models. However, their services and programs do not yet reflect the broader spectrum of primary health care services. In terms of contributors, the intention is to eventually develop interdisciplinary teams, but this feature does not currently exist.

Community Health Centres

CHCs are non-profit organizations governed by boards of directors whose membership is largely derived from clients and the community. They serve an identifiable and local community that is defined by geographic area or groups experiencing barriers to access. CHCs provide accessible outreach services and are a first point of contact for primary health services that include health, social, rehabilitative, and other non-institutional services, accenting illness prevention, health promotion, and health education. CHCs apply community development principles and work in partnership with various organizations, community agencies, and institutions (e.g., other government sectors such as education and justice, and community health boards, community hospitals) in developing a healthy local community. Services are client-focused and delivered using interdisciplinary teams. CHCs can be funded through a variety of mechanisms. For example, capitation funding for health services, program funding for community initiatives, and community fund-raising. Health care providers are paid salaries with the exception of some physicians who may employ alternative funding arrangements.

Community Health Centres exhibit more of the desired characteristics found in the criteria on governance as well as some of those related to integration and linkages. Services and programs can vary among CHCs, but generally they address the determinants of health and are responsive to community needs more so than the FHN model. CHCs tend to reflect the desired characteristics related to contributors. Many have interdisciplinary collaborative teams of providers, again, reflecting the needs of the community.

Group Family Physician Practice

This model involves more than one family physician in a self-administered privately owned practice that is usually an office setting. Services delivered include acute episodic care, continuing care, prevention, promotion, education, and advocacy. Generally physicians in group practice are remunerated by government on a fee-for-service basis, based on a provincially negotiated contract between the government and Medical Society. There is generally sharing of overhead costs, client records, and call. The group practice may link (i.e., communication, cooperation) with other primary health care providers outside of the group practice on a case-by-case basis, as required.

While group physician practices include an increased number of providers, they are not necessarily an interdisciplinary and collaborative team. Similar to the FHN, there is no traditional "governance" mechanism through which the community can provide input. Services and programs do not usually respond to the broad determinants of health and the broad spectrum of primary health care services. This model also generally uses informal linkages (i.e., communication) with other providers or organizations on an as needed basis.

Strengthening Primary Care Initiative Organizations

As described earlier in this report, in 1999 four communities in Nova Scotia were selected to implement and evaluate the following three implementation strategies: collaborative practice between family physician(s) and a nurse practitioner; the use of clinical and practice management information systems; and alternative payment for physicians. The sites are now sustainable primary care organizations within Nova Scotia. Three of four organizations have community-based advisory or governing boards or societies. The fourth is an established community health centre with a community-based board that is currently working with a DHA to develop an affiliation agreement. While their initial focus was on primary care, the role of these organizations has evolved to include primary health care activities such as health education (sex education and counseling in high schools, public information days, weight control programs, smoking prevention and cessation), flu clinics, foot clinics, well women and well child clinics, workshops (First Aid/ CPR, self-esteem, etc.), and community partnerships with groups such as planned parenthood, recreation department, schools, etc. Care is client-centered with an increased emphasis on health promotion and illness prevention, and is responsive to the community. They provide accessible, comprehensive service delivery through interdisciplinary (family physician and nurse practitioner) collaborative practice teams.

The SPCI sites demonstrate many of the desired characteristics found in the criteria for primary health care. They all had governance mechanisms that allowed for some form of community participation/input either directly or in an advisory capacity. In some cases, their services and programs expanded over the life of the demonstration project to include a broader primary health care focus that involved varying degrees of linkages with other community-based organizations. All sites had interdisciplinary collaborative teams, some larger than others.

Solo Family Physician Practice

This model involves a single family physician in a self-administered privately owned practice that is usually an office setting. Services delivered include acute episodic care, continuing care, prevention, promotion, education, and advocacy. Generally, the solo physician is remunerated by government on a fee-for-service basis, based on a provincially negotiated contract between the government and Medical Society. However, there are some instances where the solo physician has an alternative payment agreement that is not solely based on fee-for-service remuneration. The solo physician is solely responsible for overhead costs and may or may not share call with other physicians. The solo physician may link (i.e., communicate, cooperate) with other primary health care providers outside of the practice on a case-by-case basis, as required.

Solo physician practices are similar to group practices in that there is no traditional 'governance' mechanism through which the community can provide input. Services and programs do not usually respond to the broad determinants of health and the broad spectrum of primary health care services. This model also generally uses informal linkages (i.e., communication) with other providers or organizations on an as-needed basis.

Primary Health Care Network/Organization

One organizational model that builds on some of the concepts described in the Fyke Report and the Clair Report, such as networks of providers and organizations, is the primary health care network/organization. As we describe the direction in which primary health care renewal is moving, this model was developed to meet as many of the criteria for primary health care as possible. Its defining features include a network of organizations or providers where network members are required to participate in joint planning (identifying needs and capacity, setting targets, coordinating delivery, prioritizing services, human resources planning, etc.), monitoring, and evaluation. Network members are self-governed or governed by their respective organizations or communities. The network is linked and integrated by or within a DHA (network members or organizations have contractual agreements with the DHA that defines the services, targets, mode of delivery, financial accountability, etc.). The network also has a mechanism for receiving community input.

The network provides services and programs that address the determinants of health, and cover the continuum of primary health care services (prevention, promotion, treatment, rehabilitation, and community supports) based on the needs and diversity of the population who receives them. Some of these services and programs are currently funded through the health system. The community supports are traditionally funded through other sectors and sources. Programs, services, and community supports that are delivered by the network may be physically located in one or several settings. Programs and services are delivered by teams (not necessarily from one physical location) where team members reflect the needs of the population.

While this model is designed based on the criteria for primary health care, some of the mechanisms that would be required to support it (e.g., information technology, joint planning processes and alternative payment mechanisms for providers) are yet to be developed. It is intended to be a flexible model upon which, or within which, a community can build depending upon its needs and capacities.

Moving the System Forward

The criteria articulate the direction in which the ACPHCR would like to see primary health care service delivery move and give those who participate a standard and a direction to look toward. While the primary health care network/organization, as defined here, best meets the criteria, there are a variety of models of service delivery that will take Nova Scotia in that direction to varying degrees.

Given the gap between where we are today (in terms of organizational models) and where the criteria point, **there is no expectation that a service delivery provider, providers, or organization must "leap" to this model overnight.** In fact, as the system responds to evaluation and feedback over time, this model may evolve as well. Communities, providers, and organizations will participate in making such changes based on their particular circumstances and need. As a result, those that participate will change to varying degrees. Examples of mechanisms that can facilitate forward movement of the system are discussed in Section Four, Change Management.

Recommendations

No single model will meet the needs of all communities. As the Department of Health, DHAs, CHBs, professional groups and communities work together to change primary health care delivery, the ACPHCR recommends that

1. Communities must collaboratively develop primary health care service delivery models that best reflect their assets and meet their needs.
2. Movement toward networks must be incremental.
3. Participation by providers and communities must be voluntary.
4. Supports for change management must be provided.

As long as communities, providers, or organizations show that they are moving in the direction as outlined by the criteria, their efforts should be supported.

SECTION FOUR

SUPPORTING STRUCTURES OF THE PRIMARY HEALTH CARE SYSTEM

Governance

Key Messages

The governance of community-based primary health care networks or organizations should work toward

- Demonstrating that community participation is real and impacts decision-making
- Giving providers the opportunity to influence the direction of the organization and addressing the issues of trust, commitment and interdependence among providers who are accustomed to working independently
- Supporting collaboration and facilitating linkages among agencies within and external to the primary health care system
- Ensuring fiscal and clinical accountability, and the measurement of health outcomes
- Aligning with the primary health care goals and objectives of their respective DHA or the IWK Health Centre
- Community and organizational development of governance solutions that adapt to local situations

What is Governance?

Governance is the act, manner, or function of governing an organization. It is "the responsibility and accountability for the overall operation of an organization" (Nova Scotia Department of Health, 2000). It is often exercised through a governing board. However, governance does not occur simply because a board of directors exists. Governance exists when a governing board is charged with the responsibility and accountability for what the organization achieves and how it achieves it (Taylor, 2002, as cited by Patriquin, 2002). In the public sector, this board is a legal entity whose powers are prescribed in legislation such as a provincial statute, an act of incorporation, or an organization's bylaws (Patriquin, 2002).

The three broad areas of responsibility for governing bodies are setting strategic direction, monitoring operations, and recruiting and evaluating a chief administrative officer (Patriquin, 2002).

In order for governance to exist, there must be

1. A sufficient critical mass to generate the demand for the services as well as the interest and capacity to provide that service. Governance does not exist if there is no entity (real or virtual) to govern, and there must be a sufficient number of interested and committed individuals with the time to commit to effective governance. The infrastructure to support the board must also exist.
2. Unity of purpose. There is agreement on what business an organization is in, why a particular entity exists or should exist, and what its broadly stated contributions to society will be (Patriquin, 2002).

Purposeful governance structures are most effective in facilitating a common vision and coordinated planning towards common health outcomes for a population; providing flexibility for the reallocation of resources to meet shifts in need or emphasis; identifying opportunities for system efficiencies; and addressing the perceived and/or real barriers which prevent clients from moving freely among levels of care (Patriquin, 2002).

Governance may exist at three levels within a system. The macro governance level is the central authority that has responsibility for the public sector as a whole. The meso governance level is comprised of the regional or functional authorities. Micro level governance occurs at the single organizational level (Patriquin, 2002). In Nova Scotia, these are the Department of Health, DHAs, and local organizations, respectively. Given existing legislation, Community Health Boards (CHBs) are not governing bodies[1].

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[1] *Community Health Boards have the responsibility to and serve as a mechanism for obtaining community input into health care planning and decision making. The Boards assess local needs, develop plans to coordinate primary health care, and identify ways to improve the overall health of the community.*

Governance in Nova Scotia's Primary Health Care System

History

In Nova Scotia, the public has had a long history of involvement in the governance of health services. Numerous health organizations in this province were initially founded through the interest, commitment, and financial support of communities and/or religious orders. Communities of interest created boards comprised of interested and committed citizens to fund-raise as well as oversee the operations of the organization. Although the structure and definition of our health care system has changed significantly over the past several decades, the maintenance of the voluntary governing board structure has allowed the participation of ordinary citizens and the traditions and values of local communities to be brought into health program funding and decisions (Patriquin, 2002).

Current Situation

Nova Scotia's Legislative Framework

At the provincial level, there are currently a number of pieces of legislation in place in Nova Scotia that shape various aspects of the health system, including governance. Key to this legislative framework is the Health Authorities Act. Proclaimed in 2001, this Act created nine district health authorities that are governed by volunteer boards. It gives governance responsibility for acute care, public health, addictions, and mental health services to the nine DHAs. The IWK Health Centre is distinguished in this legislation as a provincial health centre specializing in womens' and childrens' health.

Other relevant Acts include the Homes for Special Care Act, the Homemakers Services Act, and the Coordinated Home Care Act. Boards of directors generally govern organizations regulated by these Acts.

Organizational Level

Today there is no one governance structure among primary health care organizations in Nova Scotia. Community governance, in some form, however, is common. The nine Community Health Centres (CHCs) that are members of Nova Scotia's Federation of Community Health Centres are governed by structures that include volunteer boards of 10 to 12 community members reporting directly to the community, boards made up of elected representatives of the communities served, volunteer boards with an advisory role to the local district health authority, and an administrative board. The four primary health care organizations that were involved in the Strengthening Primary Care Initiative provide other examples of organizational level governance. Each of these has a various form of community governance that in some cases are very similar to CHC governance models. There are also numerous non-governmental health organizations that provide valuable health services and programs in Nova Scotia that are governed by voluntary boards of directors comprised of interested community representatives.

Provider Level

The various self-regulated health professions are regulated under specific professional Acts. For example, the medical profession is regulated by The Medical Act; registered nurses by the Registered Nurses Act; dentists through the Dental Act, etc. Family physicians are different from other self-regulated providers in that although they are publicly funded, the majority of them work in independent practice settings. A physician's practice is regulated by the Medical Act and accountable to the College of Physicians and Surgeons of Nova Scotia. Institutional involvement is controlled through the medical by-laws, which include medical staff credentialing protocols (Patriquin, 2002).

Following the introduction of the DHA structure in Nova Scotia, physicians with hospital involvement have been credentialed on a district basis by the DHA board. The credentialing procedure details the scope of the physician's involvement in the hospital as well as peer review processes to assess ongoing competencies. At present, DHAs do not credential primary health care physicians who do not seek to use any of their hospitals resources (Patriquin, 2002).

Rationale for Change

Based on the vision for primary health care that was developed by multiple primary health care stakeholders, there is a need to identify governance models that will lead Nova Scotia to achieve this future. Governance has also been recognized in all of Canada's major health system review reports as a critical success factor and key component of the primary health care system.

Primary Health Care Organization Governance Models

Organizational level

A wide range of governance models is available to community-based primary health care organizations, including:

a. Governance and ownership at the local level where the local board of directors has responsibility and accountability for what the organization achieves and how it achieves it. Linkages with other health care organizations and other agencies are voluntary and informal. The primary health care organization is the employer. Dependent on size and complexity of the organization, a manager may be hired to 'run' the organization or, alternatively, administrative support can be purchased from other organizations at the local or district level (Patriquin, 2002).

b. Governance and ownership at the District Health Authority level. Primary health care organizations are owned, operated, and governed at the district level. Community advisory bodies provide input and counsel to the governing board. The District Health Authority is the employer.

c. A contractual-based integrated approach. The primary health care organization continues to be owned at the local level. However, the provision of services is negotiated with and funded through the District Health Authority. An affiliation agreement for funding, service supports, etc., is executed between the two parties. The primary health care organization may maintain an existing local board to provide advice and counsel, or alternatively it may operate as a subsidiary board with assigned governance responsibilities. In the absence of a local board, community advisory bodies similar to option 'b' would be created (Patriquin, 2002).

Each of these models has its own set of strengths and weaknesses. These are summarized in Table Four on the following page.

Provider Relationships to Primary Health Care Organizations

There are three main possibilities in terms of providers' relationships with primary health care organizations:

a. Direct employment
Under direct employment, the governance structure of the organization applies to the provider, but self-regulated providers maintain their accountability to their respective college or unit.

b. A contractual agreement with a primary health care organization
In a contractual agreement, a self-regulated provider could maintain his or her independent practice, but would contract his or her services to a primary health care organization. The governance model of the primary health care organization does not directly impact on the provider.

c. An informal relationship with other providers and organizations
Those not wishing to participate fully in primary health care renewal may develop informal relationships with other providers and organizations throughout the community, while maintaining a privately owned, and administered independent practice.

TABLE FOUR

Range of Options for Governance of Primary Health Care Organizations

A **GOVERNANCE AND OWNERSHIP AT THE LOCAL LEVEL**	B **GOVERNANCE AND OWNERSHIP AT THE DHA LEVEL**	C **CONTRACTUAL-BASED INTEGRATED APPROACH**
Strengths: Decisions are made at the level where governors are familiar with local circumstances. Community enjoys sense of ownership and control. Staff feels close to decision-making and perhaps has a greater opportunity to influence same. Linkages are voluntary; therefore, when and if formal integration occurs, there is support within the organization's leadership.	**Strengths:** Coordinated planning and services delivery through horizontal and vertical integration. District held fiscally and clinically accountable, and accountable for outcomes. Allows for provision of primary health care services to areas that do not have critical mass to create and govern their own organization. Administration and information supports for governance exist. Community participation is achieved through representation on board and through community advisory councils.	**Strengths:** Coordinated planning and services delivery through horizontal and vertical integration. District held fiscally and clinically accountable, and accountable for outcomes. Primary health care organization continues to be owned locally (seen as positive from community perspective). Administration and information supports for governance exist. Community participation is achieved through representation on board and through community advisory councils.
Weaknesses: Planning & service delivery are not coordinated with similar or other levels of care. Governors more likely to focus on management and administration instead of strategic directions and performance.Governors need to be supported by appropriate infrastructure and risk management.Linkages and informal arrangements may break down if one party perceives shift in stature, power, or autonomy. Local governance structure does not ensure true community participation and control. The community may not have sufficient critical mass to support the organization or services.	**Weaknesses:** Existing primary health care organizations may perceive a loss of control. Existing primary health care organizations may own buildings and other assets. Could be expensive to implement. Ownership does not guarantee a shared commitment to a common vision and goals.	**Weaknesses:** Existing primary health care organizations may perceive a loss of control. Potential for inefficiencies, i.e., where the DHA and locally owned organization may duplicate administrative resources.

(Adapted from Patriquin, 2002)

Recommendations

Criteria for Governance

Building on the vision for primary health care, and based on the information presented here, the governance model of a community-based primary health care network or organization should work toward meeting the following criteria:

1. The governance model(s) demonstrates that community participation is real and makes an actual impact on the decisions made by the organization.
2. The governance model(s) gives providers the opportunity to influence the direction of the organization.
3. The governance model(s) addresses the issues of trust, commitment, and interdependence between providers accustomed to working independently.
4. The governance model(s) nurtures and supports collaboration by the adoption of common goals that are singularly unattainable, and by the development and adoption of collaborative practice agreements.
5. The governance model(s) includes a fiscal accountability framework.
6. The governance model(s) ensures that health outcomes are measured.
7. The governance model(s) includes a framework for clinical accountability.
8. The governance model(s) provides flexibility so that communities and organizations can develop governance solutions that adapt to local situations.
9. The governance model(s) facilitates linkages among agencies within and external to the primary health care system in order to work collectively to improve the health of a population.
10. The governance model(s) demonstrates alignment with the goals and objectives of the respective DHA or the IWK Health Centre.
11. Government's role is to provide system leadership, funding, broad standards setting, evaluation, and protection of the public interest.

Accountability

Key Messages

The primary health care system and service delivery organizations within that system should work toward

• Clearly defining the accountabilities of all stakeholders

• Effective and innovative public consultation, public communication, community mobilization and participation

• Making information about their health needs, the goals of primary health care, and the benefits and costs of services available to individuals and families

• Ongoing evaluation and supporting informed, evidence-based decision making with performance and outcomes standards, and providing incentives for renewal

• Valuing and responding to the diversity and unique assets and needs of individuals and communities in planning and service delivery

What is Accountability?

In 1997, the Nova Scotia Department of Health defined accountability as the obligation to answer for a responsibility that has been conferred (Accountability in Nova Scotia's Health System, 1997). Within this definition, accountability assumes the existence of at least two parties:

- the party who assigns responsibility (the "assigning party")
- the party who accepts responsibility with an obligation to report back to the party that assigned the responsibility (the "accepting party")

There are three key phases of the accountability process:

- responsibility assignment and setting performance expectations
- reporting
- evaluation

In this relationship, once responsibilities are allocated, the assigning party must clearly articulate its performance expectations to the accepting party. The accepting party must ensure that it provides to the assigning party the information that is required to proceed to the evaluation phase of the accountability process. The assigning party analyzes the information provided in the reporting phase to ensure that the accepting party is meeting its responsibilities and making progress towards achieving the established goals. The ongoing evaluation process enables both parties to make decisions based on the best available information.

A different understanding of and appreciation for accountability and its resulting relationships has evolved since that time. While some of the concepts in the earlier definition of accountability remain unchanged (i.e., reporting and evaluation for example), the manner in which the accountability relationships are determined is changing. The vision for primary health care articulates accountability in terms of a participative process and mutually agreed upon relationship. In terms of the vision for primary health care, accountable means that:

- Those who receive and provide care as well as those who govern the health system and work on behalf of communities have clearly defined and specific areas of accountability.
- Health information and data are available and accessible so that individual, family, community, health professional, and government decision making is based on sound evidence.
- There is ongoing evaluation of the primary health care system related to needs, standards, efficiency, and effectiveness.
- Communities participate in identifying and supporting methods used to promote health and to deliver primary health care services.

Current Accountability Relationships in Nova Scotia's Health Care System

Legislated Accountability Relationships

The Nova Scotia Government confers on the Minister of Health the overall responsibility for the province's health care system including the services and facilities funded by the health care budget. The Minister is accountable to the Executive Council (Cabinet). The Department of Health is the agent of the Minister who is the head of the Department. Responsibilities of the Department of Health include:

- setting the strategic direction for the health care system and developing provincial plans, policy and standards which enable accountability and support that direction
- providing funding to health authorities, physicians and other health service providers in the provincial health system
- monitoring, evaluating and reporting on performance and outcomes across the health system
- ensuring quality health services are available for Nova Scotians

Through the Health Authorities Act (2000, c.6, s.1), the Minister confers responsibility to govern, plan, manage, monitor, evaluate, and deliver health services in a specifically defined area of the province to District Health Authorities and the IWK Health Centre. In the accountability relationship between the Minister and the DHAs and IWK Health Centre, the Minister is the assigning party, and the DHAs and IWK Health Centre are the accepting parties.

DHAs are responsible for establishing and supporting community health boards (CHBs), and for conferring on the boards the responsibility for fostering active public participation in health planning and annually recommending priorities for the delivery of community-based health services to the DHA. In this accountability relationship, the DHAs are the assigning parties and the CHBs are the accepting parties.

Other Accountability Relationships

Because of the breadth of the primary health care system, there are many more accountability relationships in primary health care than those covered by the Health Authorities Act. Other relationships are covered by different legislation, such as the relationship between regulated health professionals and their regulating organization. For example, through the Medical Act, physicians are accountable to the College of Physicians and Surgeons of Nova Scotia. Other relationships are not covered in legislation. For example, the Board of Directors of a community health centre may have an accountability relationship with its funding agency and the communities that it serves.

Rationale for Change

While legislation clearly defines a few of the accountability relationships within the primary health care system, there are many relationships that are not clearly articulated. For example, a population health approach to primary health care suggests that there are key roles to be played by government departments in various sectors beyond health. These could include, for example, the Departments of Education, Transportation and Public Works, and Environment and Labor. However, there is no clear set of responsibilities for population health outcomes assigned to other provincial government departments. Another example would be the lack of a clearly defined accountability relationship between academic partners and the Department of Health. Academic partners educate the health providers who comprise the primary health care system, while the Department of Health is responsible for the health care system that compensates primary health care providers. Yet there is no agreed upon accountability relationship between these two parties that are responsible for inherently linked functions.

Accountability relationships in the current primary health care system are complex and not always clear, particularly for the public. During the consultation processes held by the Romanow Commission, Canadian citizens expressed "suspicions about the way governments have managed their health care system and where the money goes" (Romanow, 2002, p. 63). Romanow noted, "People are no longer prepared to simply sit on the sidelines and entrust the health system to governments and providers. They want to be involved, engaged and acknowledged, and well informed as owners, funding agencies, and essential participants in the health care system (Romanow, 2002, p.49). He suggested that governments have a responsibility to clarify roles and responsibilities within the health care system, explain in open and understandable terms how health care dollars are allocated, and inform the public about the performance of the system (Romanow, 2002, p. 63).

Enabling the public to become well-informed about the primary health care system requires that accurate information about performance be collected, compiled, and shared on a regular basis. Access to this type of information requires the implementation of information technology systems that support the collection, analysis, and reporting of performance data.

Options for Accountability in Primary Health Care

Relationships Between Primary Health Care Organizations and Their Clients

In 1999, the Health Services Restructuring Commission (HSRC) in Ontario recommended numerous mechanisms to ensure accountability. One mechanism that ensures accountability between primary care organizations and the people that they serve is client registration with one specific organization. The rights and responsibilities of the client and organization are clearly outlined in an enrollment contract that specifies items such as

- the defined range of services provided by the organization
- hours of operation

- mechanisms for ensuring a 24-hour response to urgent care issues
- client commitment to seek primary health care services at the organization with which they are enrolled except in the case of emergencies or when services are not part of the contract
- minimum period of commitment to the organization
- mechanisms for compliments and complaints

The Ontario HSRC also recommends that primary care organizations have a formal system of reporting their performance to their registered population (HSRC Report, 1999).

Relationships Between Primary Health Care Organizations and Their Funding Bodies

In his review of the Alberta health system, Mazankowski (2001) suggested that the government establish multi-year contracts between the province and regional health authorities, setting out performance targets to be achieved and budgets to be provided. Similarly, in a review of the Saskatchewan health system, Fyke (2001) recommended a quality-oriented, accountable, and performance-driven system with the appropriate incentives and funding mechanisms. Such mechanisms might include payments and reward systems geared toward quality, illness prevention, and health promotion; achievement of goals as part of performance contracts with managers; a provincial funding system based in part on performance, rather than just volume or population need; and a funding formula for districts that rewards quality and health status improvements. Performance contracts were also recommended by the Quebec health and social services review commission (Clair, 2001).

Reporting on Primary Health Care Performance

The Romanow Commission stated, "Good information systems are essential to a high quality health care system. They allow health care providers, managers, and policy makers to share information and use the best available evidence to guide their decisions. They can also forge a strong link between quality on the one hand and accountability on the other" (Romanow p77). Other provincial heath system review commissions have underscored the importance of implementing adequate information systems to provide the data that is required for health system performance monitoring and accountability. Additional details and recommendations about information systems are contained in a subsequent section of this report.

Recommendations

Criteria for Accountability in Primary Health Care

The ACPHCR believes that all Nova Scotians share responsibility for their health and the health of their communities, and, as such, accountability relationships should reflect this. Building on the vision for primary health care, the ACPHCR recommends that the primary health care system and service delivery organizations within that system strive to improve accountability by working toward meeting the following criteria:

1. Accountabilities within relationships are clearly defined for
    - Department of Health and other relevant departments/sectors
    - District Health Authorities and the IWK
    - Community Health Boards
    - Community-based organizations
    - Primary health care organizations
    - Academic partners
    - Private sector partners
    - Third Party Payers
    - Providers, professional associations, and other contributors
    - Individuals, families and communities

2. There is a commitment to effective and innovative public consultation, public communication, community mobilization and participation, and functional integration in planning, health promotion, and primary health care service delivery.

3. Individuals, families, and communities have information about their health needs and the goals of primary health care provided in a way that they can understand and use. This information will support their decisions and assist them in setting priorities to maintain and improve their health status.

4. Consumers and providers are given information on the benefits and costs of services.

5. Performance and outcome standards are used to support informed, evidence-based decision making.

6. Adequate resources are in place to measure outcomes and to provide appropriate incentives to renew the primary health care system and improve the health status of Nova Scotians.

7. The primary health care system is evaluated on an ongoing basis related to meeting community needs, efficiency and effectiveness, financial accountability, and standards of care and service.

8. Human resources planning and development takes place in a coordinated fashion among government, districts, organizations, communities, health professionals, the academic sector, and others.

9. Planning and service delivery demonstrate commitment to valuing and responding to the diversity and uniqueness of individuals and communities.

Funding

Key Messages

- **The primary health care system should be funded using a population-based approach that attempts to match resource allocation to different levels of health status, health care needs, and services required to serve different populations.**
- **The objective of population based funding is to**
  - **improve access and continuity of health services**
  - **promotes integration of health services**
  - **enhances health promotion and illness prevention**
  - **supports the most appropriate health care provider, or team of providers, to provide primary health care services in the most appropriate settings**
  - **provides incentives to improve quality, effectiveness and efficiency where evidence and/or best practice supports those improvements**

Current Funding in Nova Scotia's Primary Health Care System

The overall health care system in Nova Scotia is funded through revenues generated from federal, provincial, and, to a lesser extent, municipal taxation. The provincial government is the main intermediary that currently funds health care providers and primary health care organizations. Funding amounts are based predominantly on past and existing costs, past negotiations, and the business planning processes.

The Department of Health does not specifically designate funds for primary health care. Rather, it allocates a global budget to each of the nine DHAs and the IWK Health Centre, which in turn funds local health services such as acute care, emergency services, and some community health centres. The DHAs, however, have protected funding for public health, mental health, addiction services, and tobacco control programs.

Rationale for Change

Nova Scotia ranks second highest among Canadian provinces for the level of health care funding as a proportion of total provincial government spending. Nova Scotia spends greater levels than most other provinces in the areas of hospitals and physician services, and proportionately less in other areas of health care such as public health, administration, and capital expenditures (Interim Report of the Funding Task Team, 2002).

The current approach to funding primary health care does not directly link the health status of the population with the funding methodology. As a result, despite having a comparatively high level of resources allocated to health care in this province, the population of Nova Scotia has a lower health status than most other provinces (GPI Atlantic, 2002).

...despite having a comparatively high level of resources allocated to health care in this province, the population of Nova Scotia has a lower health status than most other provinces...

Options for Change

In 2002, the Nova Scotia Department of Health created the Primary Health Care Funding Methods and Remuneration Task Team. The Task Team was comprised of key stakeholders representing the primary care medical community, nurses and nurse practitioners, community pharmacists, community health boards, district health authorities and the Department of Health. The Task Team was mandated to

- explore current funding approaches for primary health care and compare the experience in Nova Scotia with funding approaches in other jurisdictions
- propose options for funding the renewed primary health care system in Nova Scotia
- propose options for DHAs to consider when allocating primary health care funds to their programs, services and organizations
- propose alternative mechanisms for remunerating physicians in the renewed primary health care system

In November 2002, the Task Team completed the first two of their four tasks, and presented their Interim Report to the ACPHCR. The Interim Report (November, 2002) recommended that Nova Scotia move towards a population-based funding mechanism for primary health care in an evolutionary and incremental manner. Population-based funding is a mechanism, or a mix of mechanisms, that attempts to match resource allocation to different levels of health status, health care needs, and services required to serve different populations. The task team also identified the following ways of identifying populations for the purpose of developing a funding mechanism:

- geographically defined populations
- identifying population subsets (such as under-served, illness-based, culture)
- service provider population
- enrollment

The Task Team suggested that a population-based funding mechanism that achieves the following objectives, should be adopted for primary health care:

- improves access and continuity of health services
- promotes integration of health services
- enhances health promotion and illness prevention
- supports the most appropriate health care provider, or team of providers, to provide primary health care services in the most appropriate settings
- provides incentives to improve quality, effectiveness and efficiency where evidence and/or best practice supports those improvements

The Interim Report contained analyses about different options for population-based funding mechanisms, including different options for defining populations and determining funding adjustments (such as for population characteristics like age, gender or socio-economic status). It also identified "preferred characteristics" of a population-based primary health care funding mechanism, which suggest the funding mechanism should:

- provide incentives to achieve better health
- be resistant to manipulation and avoid perverse incentives
- recognize necessary fixed costs in primary health care infrastructure
- balance the use of comprehensive, acceptable, responsive and flexible adjustments with feasibility, validity, and reliability

Recommendations

Criteria for Primary Health Care Funding

Building on the vision for primary health care, the ACPHCR recommends that the primary health care system and service delivery organizations within that system strive to improve funding mechanisms within the system by working toward meeting the following criteria:

1. Funding promotes the most appropriate match of dollars to community primary health care needs, including financial incentives for targeted health promotion and disease prevention outcomes.
2. Funding provides incentives for increased access based on individual and comprehensive community characteristics, including but not limited to age, gender, race, socio-economic status, geography (rural isolation), and language barriers.
3. Funding is flexible enough to recognize and maximize existing community assets (i.e., community fund-raising, volunteers, corporate resources in the community, employers, hospital or health foundations and auxiliaries, etc.) and allow for community level fund-raising and accessing non-traditional funding sources.
4. The funding approach accounts for fixed and capital costs of running a primary health care organization (e.g., IT costs, administration support, heat, lights, rents, etc.).
5. Funding is adjustable for disease prevalence that typically places a high demand on the primary health care system.
6. Funding is responsive to the determinants of health, to the extent possible.
7. Any cost savings in one part of the health system as a result of good primary health care should be reinvested to other parts of the primary health care system, that require further supports.
8. Funding for primary health care is non-portable.
9. The funding approach includes funding for a variety of professions such as pharmacists, physiotherapists, and social workers, based

on the characteristics of the population served. Funding is also be provided where appropriate for children's day care, eldercare, transportation, etc.

10. Blended funding (alternative funding plus fee-for-service) is available in situations where particular services or interventions need to be encouraged.
11. The funding approach recognizes and builds on current successful services and programs.
12. The funding approach includes the initial recruiting costs for new providers, contributors, and positions.

Other Recommendations

1. The ACPHCR supports the ongoing development of a population–based funding approach for primary health care that is based on thorough evaluation and evidence, where available, and is incremental and evolutionary.
2. The funding approach should reflect following preferred characteristics:
   - provide incentives to achieve better health
   - be resistant to manipulation and avoid perverse incentives
   - recognize necessary fixed costs in primary health care infrastructure
   - balance the use of comprehensive, acceptable, responsive, and flexible adjustments with feasibility, validity, and reliability
3. The Department of Health should continue and complete the work begun by the Task Team on Primary Health Care Funding Methods and Remuneration. This includes the development of
   - proposed options for DHAs to consider when allocating primary health care funds to their programs, services and organizations
   - proposed alternative mechanisms for remunerating physicians in the renewed primary health care system

Change Management for Primary Health Care Renewal

Key Messages

- Change management, evaluation and information technology are key supports for primary health care renewal
- A strong, shared vision is a requirement for promoting change
- The planning and implementation of change should involve as many stakeholders as possible and include opportunities for them to identify similarities and differences in core values and beliefs
- Multiple change management strategies that include and reflect the unique needs of the various groups and individuals involved in primary health care renewal are required
- A mechanism for evaluation that will support improvements at the community level while allowing for regional and national comparisons is needed
- Transitional steps, which are supported by change management strategies, must be taken to prepare the primary health care system for the implementation of the electronic patient record

The Need to Manage Change

The previous chapter of this report identified that while the criteria established by the ACPHCR articulate the direction in which the primary health care system should move, it is also recognized that the change required to get there will not happen overnight. Moving in this direction will require health care providers, consumers and policy makers to change behavior and, in some cases, shift attitudes.

According to Health Canada (2002), the required shift in perspective will include a shift to a population health approach, which incorporates collective health outcomes, a more holistic, comprehensive approach, environmental change (in policies, services, and social, economic, and physical conditions), and a focus on prevention. This shift also includes responding to the determinants of health, which include gender and culture, healthy child development, health services, education, and personal health practices.

The provincial vision for primary health care also recognizes the need to include those who have historically faced barriers (due to such things as poverty, ill health, gender, race, lack of education, disability and sexual orientation) in the renewal of primary health care. Given the magnitude of the required shift in attitudes, behaviors, and focus, it is easy to understand and appreciate the need for incremental change.

The proliferation of literature on change management offers many theories that attempt to explain the necessary elements for change. Ultimately, one common theme in the literature is that a strong, shared vision is a foundational element in promoting successful change. The importance of work such as the Vision for Primary Health Care in Nova Scotia and the criteria put forward by the ACPHCR serve as examples of such vehicles. They build understanding and commitment, and provide direction in planning and implementing lasting renewal in our primary health care system.

In managing expectations of the process of change in a renewed primary health care system, it is prudent to learn from the activities and experiences of other jurisdictions. Enang, Gallant, and Payne (2002) reviewed key lessons learned from regions and other jurisdictions that have been involved in primary health care renewal or reform and offer the following elements as necessary for successful system renewal:

- stability of funding
- incremental approach to change
- involvement of stakeholders (including the users of health services)
- planning for implementation
- staffing and skill mix issues
- development of primary health care teams

Four significant areas of change are targeted in making the transition to the proposed renewed primary health care system. They include providers, the public, evaluation, and information technology.

Strategies for Managing Change - Primary Health Care Providers

Due to the current structure of our health care delivery system and the complexity of primary health care renewal, a single plan for managing change is not realistic. Multiple strategies or interventions are necessary to respond to the unique needs of each provider community. Following are some of the considerations for developing such strategies.

Examples of incentives that facilitate the engagement and behavioral change of health care providers include providing sufficient time, resources, managerial support and information systems in both clinical- and population-based working environments (Skinner, 2001, as cited in Enang, Gallant, and Payne, 2002). As change management includes both content and process dimensions, processes need to be established to deal with common challenges faced by providers participating in innovative activities (Senge, 1999, as cited in Enang, Gallant, and Payne, 2002). Such processes include having a clear vision, leadership, and appropriate provider change zsupport. In fact, effectively managing change can often be more a matter of leadership skills than management skills.

A sense of ownership is also an important component of the change process. Providing as many opportunities as possible for health care providers to be part of the implementation process will assist in building on progressive primary health care practices. Educational and training strategies are also helpful in the movement toward a renewed primary health care system. Involvement of providers in the development of educational and orientation content is essential because not only are they content experts, but acceptance of the change will begin with their contribution to developing the content and design of educational programs.

Primary health care providers' understanding of team behavior and partnerships is also key to successful primary health care renewal. Partnerships will be required within professions, between professions, both within and outside of the health system, at local, regional, and national levels. In order to achieve true partnership and participation between health care providers, an understanding of and possible change to health care providers' attitudes, beliefs, and behaviors needs to be developed. Opportunities should be made available to primary health care providers, separately and together, to identify similarities and differences in core values, beliefs, and interests. Educational strategies, as well, should incorporate practical, meaningful primary health care experiences for health providers if core values are to be modified or changed (Enang, Gallant, and Payne, 2002).

...health care providers will need to demonstrate patience, flexibility, a good understanding of primary health care processes, and a willingness to "meet people where they are".

Health Canada (2002) also suggests that in a renewed primary health care system, health care providers will need to demonstrate patience, flexibility, a good understanding of primary health care processes, and a willingness to "meet people where they are". This involves being non-judgmental, accommodating community needs related to things such as meeting times, locations, styles, language, culture, and customs. Considering other barriers such as childcare and transportation difficulties are also part of this approach.

Strategies for Managing Change - The Public

As stated earlier, primary health care renewal will require not only providers, but also the public to shift attitudes and behaviors. However, before attitudes and behaviors can change, education needs to occur. The public's understanding of what primary health care is, and why and how the system needs to change is essential. Given that every individual's and communities' capacity for learning and receiving information are different, multiple and creative strategies will be required to facilitate this education. This approach will ensure that all Nova Scotians, including those who have traditionally been excluded from the health care system, receive the message.

Another key component that needs to be part of this change management strategy is educating individuals and the public about what their roles and responsibilities are within a renewed primary health care system. This includes increasing individuals' and communities' capacity to manage their health, and participate in primary health care planning and decision-making. Part of this may also involve increasing their awareness of the many primary health care contributors, and their roles, responsibilities, and qualifications.

In managing public and individual expectations throughout the process of renewal, two of the elements of success that have been learned in other jurisdictions are directly relevant to the public. These are the notions of an incremental approach to change, and the involvement of the public as a stakeholder. An incremental, step-wise approach should provide a sense of security that this change will happen in a reasonable versus rushed timeframe. The involvement of the public in planning and decision-making for the health system should also ensure a sense of ownership similar to that described for providers.

Recommendations for Change Management

The ACPHCR Recommends that:

1. The Department of Health take a leadership role in developing a multi-level change management strategy that involves all partners including the Department of Health, other government departments, DHAs, CHBs and communities, providers, the public, and populations that are traditionally excluded from primary health care.

   The strategy:

   a. is supported by an integrated communication and marketing strategy that educates all stakeholders about the change, why it is important, and how it will affect them

   b. requires DHAs to provide resources and support to CHBs and communities to enable them to participate in the process of change management

   c. should support an ongoing process that enables a broad range of providers from many disciplines to dialogue or share their perspectives on collaboration in primary health care

   d. must ensure that people who have not traditionally participated in planning participate in the change process. For example, the strategy should find or use different ways of engaging different population groups in CHB planning and change management activities

   e. must include specific plans and resources for change management as it relates to addressing jurisdictional issues faced by First Nations

2. The Department of Health and DHAs must dedicate adequate funding and resources to support the change management strategy.

3. People who are skilled in transition and change management must be recruited to champion the change management process at the Department of Health and DHAs levels.

4. The Department of Health must cooperate and collaborate with the newly formed Office of Health Promotion on relevant primary health care renewal activities.

Evaluation in Primary Health Care

The ACPHCR has identified evaluation as an important area for immediate development. Evaluation in primary health care is critical for several reasons:

- to assist with continuous quality improvement activities at the community level
- to support performance reporting at the regional and provincial levels
- to track the effects of reform in primary health care across the country
- to support the process of change management

Nationally, there is very little health information currently available in the area of primary health care to assist in evaluating the effectiveness, efficiency, and responsiveness of primary health care services. In Nova Scotia, the identification of indicators that can be derived from data from the information systems in the four Strengthening Primary Care Initiative organizations will be important in the development of a framework for primary health care evaluation.

Equally important will be the standardization of data and indicators so that national reporting can be facilitated. The Primary Health Care section will continue working with the Performance Measurement and Health Informatics section of the Department of Health in evaluation initiatives, including the development of a performance indicator framework for the province of Nova Scotia.

The purpose of this work is to

- develop a framework for the implementation and maintenance of indicators that are required to support all levels of health and health systems management, and provide for the development and inclusion of future indicators
- develop a minimum data set for the indicators and begin populating the framework

Another significant strategy will be to collaborate with key stakeholders such as researchers, other government departments, health provider organizations, and other health organizations to craft a consensus on an evaluation strategy for primary health care. This will facilitate buy-in by these groups as well as increase the relevance and validity of the project results. Additionally, the development of partnerships with academic institutions and other research organizations will be critical to build on work that has already been done and to make the most of existing expertise in the field.

Recommendations

The ACPHCR recommends that

5. The Primary Health Care Section of the Department of Health should collaborate with key stakeholders to develop and implement a system of evaluation that will support program evaluation and ongoing improvement in the quality of primary health care at the community level while allowing regional and national comparisons.

Information Technology in Primary Health Care

Despite significant advances made over the past eight years, the current status of the use of information technology in the primary health care system illustrates the need for continued efforts towards improvement. In terms of the primary care component of primary health care, the current system consists of approximately 750 family physicians mostly in solo or group practices, where technology-based information systems to support effective and efficient primary care delivery are not widely used.

Information systems are critical to primary health care for many of the same reasons as evaluation, namely to collect information that will

- support evaluation and performance reporting at the regional and provincial levels
- assist with continuous quality improvement activities at the community level
- track the effects of reform in primary health care across the country
- support the process of change management

Information systems are also critical from the perspective of providers, in that they support providers in the delivery of care to their clients through the provision of a current at-hand record of the individual's health information in a searchable format.

Current Situation

As part of a provincial health information strategy, Nova Scotia is moving toward the implementation of an electronic health record (EHR) for the entire health system. The electronic health record is a composite of an individual's health-related information that will include relevant information from encounters with the health care system including visits with primary health care providers. Electronic Patient Records (EPR), which are the electronic version of the traditional patient paper chart, are a necessary pre-requisite to implementation of the EHR. It is estimated, however, that less than 5 per cent of primary health care providers currently use EPR systems. While current efforts have focused on the development of the Nova Scotia Hospital Information System (NShIS), it is imperative that the primary health care system lay the foundation of EPRs as we evolve toward province-wide electronic health records.

One example of information technology in primary health care is within the four SPCI organizations. Each of these organizations are using clinical and practice management software to support primary care service delivery and to participate in the evaluation of the Initiative. The SPCI Progress Report, released in March 2001, detailed lessons learned to that date. Highlighted in the information management/information technology (IM/IT) area was the need for careful planning for change, support for education and training, user and stakeholder involvement, and the considerable support required in adopting advanced IM/IT systems. The final evaluation of SPCI, which is expected in the spring of 2003, will provide further direction to information management and information technology in primary health care.

Further to this, targeted activities under the Primary Health Care Transition Fund initiative intend to significantly expand upon the number of Nova Scotian primary health care providers that use EPR systems. Such EPR systems, generally known as clinical management systems, should include interfaces to diagnostic services for ordering and results delivery. Some of the necessary transitional steps that will be addressed in this initiative may include the development of core data and charting standards, development of provincial procedures to support conformance of software vendors, and ongoing training in the use of primary health care information systems.

Challenges in Information Technology in Primary Health Care

Information technology related challenges in primary health care include

- primary care provider access to a comprehensive Health Information Network
- lack of data standards among the primary health care provider disciplines
- inadequate collaboration on technology issues between program areas under the primary health care umbrella
- management of privacy and security issues
- provider transition to new technologies
- vendor convergence and changing technology
- funding

Recommendations

The ACPHCR Recommends that:

6. The Department of Health lead and ensure that developments in IT/IM in primary health care should be in line with the overall information strategy for the health care system in Nova Scotia.
7. The Department of Health establish incentives for the acquisition and use of primary health care software and hardware, which will also aid in the transition to electronic patient records and the electronic health record.
8. The following transitional steps be addressed by the Department of Health to enable the implementation of a primary health care EPR as part of the overall EHR for each person in Nova Scotia:
   - Develop core data, recording, and privacy standards
   - Develop provincial procedures to support the conformance of software vendors
   - Develop change management strategies to support adoption of the EPR in primary health care settings
   - Offer ongoing training to users of primary health care information systems
   - Develop a funding strategy for implementation and maintenance of EPR systems in primary health care
   - Liaise with other components of the Nova Scotia EHR to ensure integration and connectivity

SECTION FIVE

NEXT STEPS FOR PRIMARY HEALTH CARE RENEWAL

Key Messages

- **An incremental and voluntary approach will be key to the success of primary health care renewal**
- **Endorsement of the direction recommended in the report and a commitment to a sustainable resources plan for the primary health care system by the Department of Health are required**
- **The Department of Health and DHAs need to work together to communicate and educate the public and other stakeholders about primary health care renewal and to develop and implement a change management strategy**
- **CHBs require dedicated funding to fulfill their mandate**

Next Steps for Immediate Action

The ACPHCR has put forth to the Department of Health a set of criteria and a number of recommendations that, if acted on, will bring about real change in the primary health care system in Nova Scotia. An incremental and voluntary approach to primary health care renewal will be key to its success.

There are, however, a number of specific activities that must take place in the immediate future. Responsibility for these immediate next steps largely rests with the Department of Health and DHAs. The ACPHCR Recommends that

1. The Department of Health publicly endorse the direction recommended by the ACPHCR.
2. The Department of Health secure a commitment to a sustainable resource plan for the primary health care system. This must include a commitment to information technology and human resources for expanded inter-disciplinary teams.
3. As part of this resource plan, the Department of Health and DHAs commit to dedicated funding for CHBs to ensure that they have adequate resources to fulfill their legislated mandate. By doing so, the critical role that volunteers play in the health care system will be recognized.
4. The Department of Health, DHAs, and IWK Health Centre work together to undertake planned and thorough marketing and communication of the contents of the report to educate the public and other primary health care stakeholders about primary health care renewal in Nova Scotia.
5. The Department of Health, DHAs, and IWK Health Centre work together to make information available so that all Nova Scotians understand the health issues and health status of their geographic, cultural, and ethnic communities. This involves the dedication of resources to support gathering and sharing this information and to building the capacity of the community to use the information.
6. The Department of Health lead and work with DHAs and the IWK Health Centre to develop timelines and implement the change management strategy identified in this report.
7. The Department of Health develop a strategy to overcome the jurisdictional issues that are barriers to the full participation of First Nations in the planning and delivery of primary health care.
8. The Department of Health work with DHAs, the Medical Society of Nova Scotia, and others to develop options for alternative funding arrangements for family physicians.
9. In order to learn from our experiences in primary health care renewal, the Department of Health work with DHAs and the IWK Health Centre to develop a tool or mechanism to measure health outcomes and the impact of changes to primary health care. The tool should

a. allow for the creation of a baseline of information on the performance and outcomes of the current system

b. provide for the sharing of information with communities, CHBs, DHAs and other health planners

c. ensure the consistent methods of information collection across DHAs

CONCLUSION

The vision for primary health care, developed in consultation with primary health care stakeholders, has guided the work of the ACPHCR. It is the cornerstone of primary health care renewal in Nova Scotia. The vision reflects Nova Scotians' commitment to work together so that in 15 years our health status will be improved as a result of all Nova Scotians being enabled to positively influence the many factors that influence health. Communities will be supported in their efforts to improve health by a primary health care system that is community-based, family focused and person-centred, comprehensive, responsive and flexible, accessible, integrated, collaborative and innovative, accountable, and sustainable.

Among the Nova Scotia Department of Health's strategic directions for 2002-03 was one to "design and implement a primary health care system that meets the needs of Nova Scotians." From its inception, the ACPHCR took action to address this strategic direction and fulfilled its mandate to advise the department on the development of a community-based primary health care system based on a population health approach. The recommendations and criteria for primary health care put forward by the ACPHCR in this report provide tangible opportunities for incremental change that will ultimately lead to the realization of the provincial vision for primary health care.

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APPENDICES

Appendix One

Recommendations of the ACPHCR

Services and Programs:

Criteria for Primary Health Care Services and Programs

Building on the vision for primary health care, the ACPHCR recommends that primary health care system and service delivery organizations work toward delivering services and programs that meet the following criteria:

1. Services and programs proactively address the interaction of the determinants of health.
2. Services and programs contribute to the continuum of primary health care.
3. Services and programs are delivered in a collaborative manner.
4. Services and programs are sustainable.
5. Services and programs are based on available evidence and best practices.
6. Services and programs are provided in a manner and at times and locations that are flexible and accessible for individuals and communities.
7. Services and programs foster cooperation among communities, and are established in a way that allows communities with different capacities the opportunity to meet their needs.
8. Services and programs provide entry points to a comprehensive, seamless system that promotes continuity of care.

Other Recommendations

The ACPHCR recommends that the following list of services should, over time, become the foundation of the primary health care system:

1. Basic Emergency Services
2. Communicable Disease Prevention and Control
3. Community Mental Health Services
4. Community Supports
5. Continuing Care (Home Care, Long Term Care, Small Options Homes, Palliative Care, etc.)
6. Dental Health Services
7. Environmental Health Services
8. Health Promotion (including community development)
9. Healthy Child Development
10. Nutrition Services
11. Primary Maternity Care
12. Prevention & Treatment of Common Diseases and Injuries
13. Rehabilitation Services
14. Sexual Health and Family Planning Services
15. Other publicly funded services (services such as housing, income assistance, occupational health & safety, and education programs that are delivered by other government departments)

Contributors:

Criteria for Contributors

Building on the vision for primary health care, and based on the information presented about providers and contributors to primary health care, the ACPHCR recommends that the primary health care system and models of community-based service delivery work toward meeting the following criteria:

1. Providers and contributors work as a team.
2. Primary health care delivery involves health care providers and other contributors that reflect and are responsive to the needs of the community.
3. Collaboration or partnerships among providers and/or the community, whether formal or informal, are supported and/or enabled by one or more mechanisms which may include collaborative practice agreements, health promotion networks, intersectoral continuing education programs, networks and contractual agreements, team meetings, administrative coordination and support, and other supports and linkages.
4. In order to ensure quality and continued contribution, providers and contributors are supported by
   a. flexible and alternative arrangements and mechanisms such as alternative payment options and flexible working hours that address lifestyle issues and are responsive to community needs
   b. ongoing education and resources that support primary health care providers in both their delivery of services and in collaborating with others
5. The role of contributors and the role and scope of practice of providers are developed collaboratively and are clearly defined in the context of service delivery.
6. Training of new primary health care providers reflects the desired models of primary health care.

Primary Health Care Providers

The preferred future with respect to primary health care providers within primary health care service delivery organizations is the interdisciplinary collaborative team where the interdisciplinary collaborative team is made up of core and extended providers

a. Core providers are those with whom the client has a longer-term and continuing relationship. Extended providers are those with whom the client has shorter-term relationships at times when the client requires a specialized service.

b. In the renewed community-based primary health care system, this core team would include the family physician, family practice nurse, pharmacist, nurse practitioner, social worker, dietitian, the appropriate public health provider(s), and midwife.

c. The structure of the core and extended team will reflect the needs of the population being served. However, it is recognized that other factors such as geography will also affect the structure of a team. As a result, teams will look different in different communities. Communities and primary health care service delivery organizations may combine or coordinate their resources to ensure access to team members.

d. At the individual client (versus population) level, the team will consist of different providers at different times and for different situations.

The Department of Health, DHAs, and providers should consider the remaining recommendations of the task team that relate to the interdisciplinary primary health care team as they shape and develop teams in the future.

The Department of Health should conduct further work related to possibilities for enhanced or new roles for providers (such as paramedics, dietitians, pharmacists, social workers) who have not yet been part of an interdisciplinary team. This work should consider roles, funding, information systems, and education.

Providers of Primary Maternity Care

The primary health care system should support a collaborative team-based approach to the delivery of primary maternity care with the participation of family physicians and midwives at their full scope of practice.

a. The Department of Health should immediately establish a regulatory/licensing mechanism for midwives.

b. The Department of Health, DHAs and relevant organizations (e.g., IWK Health Centre, the Reproductive Care Program, professional groups) should work together to develop collaborative team-based models for the delivery of primary maternity care that take into account the needs and resources of individuals and the community.

c. The Department of Health should work with DHAs to develop settings for the delivery of primary maternity care services that are specifically designed to support the philosophy and practice of primary maternity care and include midwives.

d. Academic institutions, in consultation with the DHAs, Department of Health, and relevant professional groups, should develop educational experiences that reflect this collaborative team-based approach to the delivery of primary maternity care.

Family Caregivers

The Continuing Care Branch should name and involve caregivers in relevant policies, adopt and implement a standard protocol for assessing the needs of the primary caregiver, and work with various public and private organizations and agencies to develop a variety of forms of financial, emotional, information and education, and replacement care supports for family caregivers.

Other Recommendations - Providers of Complementary and Alternative Health Care

The Department of Health should conduct further work related to the possible relationship of complementary and alternative health care providers to the primary health care team. This should include consideration of issues such as access to quality information about CAM therapies, education of primary health care providers and the public, the use of CAM by certain culturally identifiable groups, possible institutional policies for CAM, and the future licensing and regulation of CAM providers in Nova Scotia.

Integration & Linkages

Criteria for Integration and Linkages

Building on the vision for primary health care, the ACPHCR recommends the primary health care system and service delivery organizations within that system work toward meeting the following criteria:

1. Opportunities for the development of planned linkages, networks, strategies, and functional integration exist among all sectors within primary health care (including governmental, non-governmental, community, academic sectors, and First Nations) and between primary health care and the secondary and tertiary health care systems.
2. Planned and organized sharing of information and resources that contribute to individual and population health takes place over time with the development of respect and trust among primary health care stakeholders and between primary health care and secondary and tertiary health care stakeholders.
3. Individuals have a confidential, common health record that includes a basic health history and current health status and may be accessed by their choice of providers with the individual's agreement.
4. Individuals and families are assisted in navigating through the health care system and the broad range of community supports and services.

Models of Primary Health Care Service Delivery

No single model will meet the needs of all communities. As the Department of Health, DHAs, CHBs, professional groups and communities work together to change primary health care delivery, the ACPHCR recommends that

1. Communities must collaboratively develop primary health care service delivery models that best reflect their assets and meet their needs.
2. Movement toward networks must be incremental.
3. Participation by providers and communities must be voluntary.
4. Supports for change management must be provided.

As long as communities, providers, or organizations show that they are moving in the direction as outlined by the criteria, their efforts should be supported.

Governance

Criteria for Governance

Building on the vision for primary health care, and based on the information presented here, the governance model of a community-based primary health care network or organization should work toward meeting the following criteria:

1. The governance model(s) demonstrates that community participation is real and makes an actual impact on the decisions made by the organization.
2. The governance model(s) gives providers the opportunity to influence the direction of the organization.
3. The governance model(s) addresses the issues of trust, commitment, and interdependence between providers accustomed to working independently.
4. The governance model(s) nurtures and supports collaboration by the adoption of common goals that are singularly unattainable, and by the development and adoption of collaborative practice agreements.
5. The governance model(s) includes a fiscal accountability framework.
6. The governance model(s) ensures that health outcomes are measured.
7. The governance model(s) includes a framework for clinical accountability.
8. The governance model(s) provides flexibility so that communities and organizations can develop governance solutions that adapt to local situations.
9. The governance model(s) facilitates linkages among agencies within and external to the primary health care system in order to work collectively to improve the health of a population.
10. The governance model(s) demonstrates alignment with the goals and objectives of the respective DHA or the IWK Health Centre.
11. Government's role is to provide system leadership, funding, broad standards setting, evaluation, and protection of the public interest.

Accountability

Criteria for Accountability in Primary Health Care

The ACPHCR believes that all Nova Scotians share responsibility for their health and the health of their communities, and, as such, accountability relationships should reflect this. Building on the vision for primary health care, the ACPHCR recommends that the primary health care system and service delivery organizations within that system strive to improve accountability by working toward meeting the following criteria:

1. Accountabilities within relationships are clearly defined for
    - Department of Health and other relevant departments/sectors
    - District Health Authorities and the IWK
    - Community Health Boards
    - Community-based organizations
    - Primary health care organizations
    - Academic partners
    - Private sector partners
    - Third Party Payers
    - Providers, professional associations, and other contributors
    - Individuals, families and communities
2. There is a commitment to effective and innovative public consultation, public communication, community mobilization and participation, and functional integration in planning, health promotion, and primary health care service delivery.
3. Individuals, families, and communities have information about their health needs and the goals of primary health care provided in a way that they can understand and use. This information will support their decisions and assist them in setting priorities to maintain and improve their health status.
4. Consumers and providers are given information on the benefits and costs of services.
5. Performance and outcome standards are used to support informed, evidence-based decision making.
6. Adequate resources are in place to measure outcomes and to provide appropriate incentives to renew the primary health care system and improve the health status of Nova Scotians.
7. The primary health care system is evaluated on an ongoing basis related to meeting community needs, efficiency and effectiveness, financial accountability, and standards of care and service.
8. Human resources planning and development takes place in a coordinated fashion among government, districts, organizations, communities, health professionals, the academic sector, and others.
9. Planning and service delivery demonstrate commitment to valuing and responding to the diversity and uniqueness of individuals and communities.

Funding

Criteria for Primary Health Care Funding

Building on the vision for primary health care, the ACPHCR recommends that the primary health care system and service delivery organizations within that system strive to improve funding mechanisms within the system by working toward meeting the following criteria:

1. Funding promotes the most appropriate match of dollars to community primary health care needs, including financial incentives for targeted health promotion and disease prevention outcomes.
2. Funding provides incentives for increased access based on individual and comprehensive community characteristics, including but not limited to age, gender, race, socio-economic status, geography (rural isolation), and language barriers.
3. Funding is flexible enough to recognize and maximize existing community assets (i.e., community fund-raising, volunteers, corporate resources in the community, employers, hospital or health foundations and auxiliaries, etc.) and allow for community level fund-raising and accessing non-traditional funding sources.

4. The funding approach accounts for fixed and capital costs of running a primary health care organization (e.g., IT costs, administration support, heat, lights, rents, etc.).
5. Funding is adjustable for disease prevalence that typically places a high demand on the primary health care system.
6. Funding is responsive to the determinants of health, to the extent possible.
7. Any cost savings in one part of the health system as a result of good primary health care should be reinvested to other parts of the primary health care system, that require further supports.
8. Funding for primary health care is non-portable.
9. The funding approach includes funding for a variety of professions such as pharmacists, physiotherapists, and social workers, based on the characteristics of the population served. Funding is also be provided where appropriate for children's day care, eldercare, transportation, etc.
10. Blended funding (alternative funding plus fee-for-service) is available in situations where particular services or interventions need to be encouraged.
11. The funding approach recognizes and builds on current successful services and programs.
12. The funding approach includes the initial recruiting costs for new providers, contributors, and positions.

Other Recommendations

The ACPHCR supports the ongoing development of a population-based funding approach for primary health care that is based on thorough evaluation and evidence, where available, and is incremental and evolutionary.

The funding approach should reflect following preferred characteristics:

- provide incentives to achieve better health
- be resistant to manipulation and avoid perverse incentives
- recognize necessary fixed costs in primary health care infrastructure
- balance the use of comprehensive, acceptable, responsive, and flexible adjustments with feasibility, validity, and reliability

The Department of Health should continue and complete the work begun by the Task Team on Primary Health Care Funding Methods and Remuneration. This includes the development of

- proposed options for DHAs to consider when allocating primary health care funds to their programs, services and organizations
- proposed alternative mechanisms for remunerating physicians in the renewed primary health care system

Change Management

General Change Management

The Department of Health take a leadership role in developing a multi-level change management strategy that involves all partners including the Department of Health, DHAs, CHBs and communities, providers, the public, and populations that are traditionally excluded from primary health care. The strategy

a. is supported by an integrated communication and marketing strategy that educates all stakeholders about the change, why it is important, and how it will affect them

b. requires DHAs to provide resources and support to CHBs and communities to enable them to participate in the process of change management

c. should support an ongoing process that enables a broad range of providers from many disciplines to dialogue or share their perspectives on collaboration in primary health care

d. must ensure that people who have not traditionally participated in planning participate in the change process. For example, the strategy should find or use different ways of engaging different population groups in CHB planning and change management activities

e. must include specific plans and resources for change management as it relates to addressing jurisdictional issues faced by First Nations

The Department of Health and DHAs must dedicate adequate funding and resources to support the change management strategy.

People who are skilled in transition and change management must be recruited to champion the change management process at the Department of Health and DHAs levels.

The Department of Health should cooperate and collaborate with the Office of Health Promotion on relevant primary health care renewal activities.

Evaluation

The Primary Health Care Section of the Department of Health should collaborate with key stakeholders to develop and implement a system of evaluation that will support program evaluation and ongoing improvement in the quality of primary health care at the community level while allowing regional and national comparisons.

Information Technology

The Department of Health lead and ensure that developments in IT/IM in primary health care should be in line with the overall information strategy for the health care system in Nova Scotia.

The Department of Health establish incentives for the acquisition and use of primary health care software and hardware, which will also aid in the transition to electronic patient records and the electronic health record.

The following transitional steps be addressed by the Department of Health to enable the implementation of a primary health care EPR as part of the overall EHR for each person in Nova Scotia:

- Develop core data and recording standards
- Develop provincial procedures to support the conformance of software vendors
- Develop change management strategies to support adoption of the EPR in primary health care settings
- Offer ongoing training to users of primary health care information systems
- Develop a funding strategy for implementation and maintenance of EPR systems in primary health care
- Liaise with other components of the Nova Scotia EHR to ensure integration and connectivity

Next Steps

The ACPHCR recommends that:

The Department of Health publicly endorse the direction recommended by the ACPHCR.

The Department of Health secure a commitment to a sustainable resource plan for the primary health care system. This must include a commitment to information technology and human resources for expanded inter-disciplinary teams.

As part of this resource plan, the Department of Health and DHAs commit to dedicated funding for CHBs to ensure that they have adequate resources to fulfill their legislated mandate. By doing so, the critical role that volunteers play in the health care system will be recognized.

The Department of Health and DHAs work together to undertake planned and thorough marketing and communication of the contents of the report to educate the public and other primary health care stakeholders about primary health care renewal in Nova Scotia.

The Department of Health and DHAs work together to make information available so that all Nova Scotians understand the health issues and health status of their geographic, cultural, and ethnic communities. This involves the dedication of resources to support gathering and sharing this information and to building the capacity of the community to use the information.

The Department of Health lead and work with DHAs to develop timelines and implement the change management strategy identified in this report.

The Department of Health develop a strategy to overcome the jurisdictional issues that are barriers to the full participation of First Nations in the planning and delivery of primary health care.

The Department of Health work with DHAs, the Medical Society of Nova Scotia, and others to develop options for alternative funding arrangements for family physicians.

In order to learn from our experiences in primary health care renewal, the Department of Health work with DHAs to develop a tool or mechanism to measure health outcomes and the impact of changes to primary health care. The tool should

a. allow for the creation of a baseline of information on the performance and outcomes of the current system

b. provide for the sharing of information with communities, CHBs, DHAs and other health planners

c. ensure the consistent methods of information collection across DHAs

APPENDIX TWO

ADVISORY COMMITTEE ON PRIMARY HEALTH CARE RENEWAL

Terms of Reference

Background

Decades of work conducted by the Nova Scotia government and a variety of stakeholders have informed the discussion about primary care and primary health care. Examples include: *The Report of the Nova Scotia Royal Commission on Health Care, The Nova Scotia Task Force on Primary Health Care, The Provincial Health Council's Initial Plan of Action for Health System Reform Report and Workbooks, Nova Scotia's Blueprint for Health System Reform, the Report of the NS Task Force on Nursing, Recommendations on the Regulation and Implementation of Midwifery in NS and the NS Medical Society's Primary Care Steering Committee Discussion Paper.* These and numerous other provincial and national reports are testaments to years of insight and comprehensive recommendations.

Early efforts to improve the funding, delivery and management of primary care in Nova Scotia resulted in the creation of the Strengthening Primary Care in Nova Scotia Communities Initiative, which is evaluating new models over a three year period ending on December 31, 2002. Much has been learned from the implementation of four demonstration projects in this Initiative, and the evaluation at its completion will further inform policy development.

In September 2001 the Department of Health adopted as policy, a population health approach to guide the work of the Department. Within this conceptual framework all the work of the Department including the renewal of primary health care will be carried out in a way that is mindful of and responsive to the principles of population health. The Department is now preparing to build on the existing primary health care system with various strategic initiatives to both improve the overall health of the population and to enhance primary health care.

Rationale

Primary Health Care renewal presents an opportunity to make improvements in various areas including sustainability, accountability, utilization of existing health care providers and health care resources, access in both rural and urban settings, integration of services, morale in the health sector workplace, the ability to measure quality of care, health promotion and illness and injury prevention, and targeting of populations in greatest need.

Purpose

In keeping with Strategic Direction #4 of the Nova Scotia Department of Health and the related goal and objectives (attached) the purpose of the Advisory Committee on Primary Health Care Renewal is to advise the Nova Scotia Department of Health on the implementation of a community-based primary health care system in Nova Scotia based on a population health approach. Critical to the mission of the NS Department of Health is an integrated, community-based and sustainable health system.

Functions

The Advisory Committee will conduct its work within a population health approach, which includes: "recognizing health as a resource for everyday living, addressing determinants of health, investing upstream (early investment to improve future health status), basing decisions on evidence, applying multiple strategies to act on the determinants of health, collaboration across levels and sectors, engaging citizens, and increasing accountability for health outcomes[1]."

The Advisory Committee on Primary Health Care Renewal will:

1. Recommend to the Department a vision and principles for a renewed primary health care system in Nova Scotia by building on the successful elements of primary health care already in place, the work of the original Primary Care Steering Committee and the stakeholder Vision Workshop.
2. Identify and recommend various community-based primary health care service delivery mechanisms for consideration in Nova Scotia.
3. Develop the criteria/components of the models identified in Function #2 including governance, integration and linkages, funding and remuneration, the role of existing and new providers, performance indicators and evaluation, information systems and electronic health records as well as others as required.
4. Provide input into the Department of Health's proposal for funding from the Federal Primary Health Care Transition Fund that will broaden and accelerate primary health care renewal and lead to sustainable improvements to the Nova Scotia primary health care system.
5. Identify mechanisms to facilitate collaboration with sectors outside health care delivery to promote linkages between primary health care service delivery and those sectors to address the broad determinants of health in order to gain long-term health status improvements among Nova Scotia populations.
6. Recommend an action plan reflecting the vision, principles and implementation models recommended by the Advisory Committee and approved by the Department of Health.
7. Assume the responsibility of the former Primary Care Steering Committee which will become a sub-committee of the Advisory Committee and will fulfill its original mandate. The Terms of Reference of the Steering Committee are attached.
8. Ensure that there is a Communication Plan that promotes open and regular communication through the Chair to stakeholders including District Health Authorities, Community Health Boards and the public at large about the Advisory Committee and the progress of its work.

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[1] *Taking Action on Population Health: Health Canada 1998*

Time Frame

The Advisory Committee on Primary Health Care Renewal will complete its mandate within a 2 year period recognizing that changing the existing primary health care system is a long term process. The Committee will meet on a monthly or as needed basis.

Accountability

Through its Chair, the Advisory Committee on Primary Health Care Renewal will report to the Associate Deputy Minister of Health and the Senior Leadership Team and make specific recommendations as required throughout its mandate. The Chair of the Advisory Committee will also present regular briefings to the Minister and Deputy Minister of Health to update them on its progress and maintain linkages to other primary health care processes both internal and external to government.

Department of Health Staff Support

The Advisory Committee on Primary Health Care Renewal will be supported by a Project Management/Policy Team from the Department of Health including the Chair (the Executive Director of Integrated Primary and Population Health), Primary Care Section staff, the Nurse Policy Advisor and staff from the following areas: Population Health and Health Systems Development.

Additional staff assistance will be available from the following areas as required: Acute Care, Home Care, Long Term Care, Information Management, Finance, Insured Services, Communications, Mental Health, Addictions, Legal and others.

Membership

The membership of the Nova Scotia Advisory Committee on Primary Health Care Renewal is comprised of broad representation from the health service delivery sector, professionals and communities. It is reflective of the diversity of the province in such factors as experience, content expertise, gender, culture and geography. The membership list is attached.

APPENDIX THREE

Population Health Approach Checklist

Many factors outside the health system significantly affect health. In a population health approach, the entire range of known individual and collective factors and conditions that determine population health status – and the interactions among them – are taken into account in planning action to improve health. This checklist was designed to help the Advisory Committee on Primary Health Care Renewal analyze health issues and to make decisions regarding programs, policies, services and supports using a population health approach, as they develop a community-based primary health care system for Nova Scotia.

Think Big Picture:

What is the situation and the circumstances that exist, and why?

What are the expected outcomes of your decision (in terms of a broad understanding of health)?

What needs to happen (resources and supports) in order to achieve these outcomes?

Think Community Participation:

Are you the appropriate representatives of the community for this decision-making?

If not, how will you include the appropriate people in the decision-making process?

How have you ensured (mechanisms for) community participation?

What mechanisms or supports need to exist to ensure ongoing community consultation?

Think Health Determinants:

In your decision-making how did you consider the impact of the wide range of factors that influence the determinants of health? (social support networks, income & social status, healthy childhood development, physical environment, biology & genetic endowment, culture, employment & working conditions, education, gender, social environment, health care services, personal health practice & healthy coping skills)

What will it take (resources and support) to achieve or implement these programs and policies?

Think Equity in Health:

In your decision-making, how have you considered the barriers and challenges that make it harder for some people to be as healthy as others (i.e. transportation, child care, income)?

Have you identified the resources and supports that are required to overcome these barriers?

How has your decision-making ensured that services/initiatives will be offered in ways that value and respond to the cultural, racial and spiritual experiences of families/persons?

Think Strategic Partnerships:

How has your decision-making involved other community groups, organizations and agencies that have a stake in the situation and circumstances that exist?

What mechanisms or supports are needed to ensure that ongoing partnerships with organizations outside of the traditional health services are developed and maintained?

Think Multi-Strategies:

Has your decision-making identified multiple ways of addressing the situation and circumstances that exist (i.e. different strategies for different people, different settings and different circumstances)?

What mechanisms or supports are needed to ensure that multiple strategies are developed and implemented?

Think Evidence:

How have you considered evidence (qualitative and quantitative) in your decision-making?

What evidence is missing and/or required?

Does your decision-making ensure mechanisms for the ongoing collection and use of evidence?

Have you considered whether an evaluation component is required?

Does your decision-making ensure that there will be ongoing mechanisms for evaluation that will be responsive to changing situations and circumstances?

Have you ensured that the impact of your decision-making can be evaluated?

What will it take (resources and supports) to ensure that evaluation occurs?

Think Capacity Building:

How does your decision-making foster personal responsibility and community action?

What mechanisms or supports need to exist to ensure ongoing community capacity building?

Think Multi-Sectors:

Has your decision-making identified multiple sectors within and outside of the health system that have a stake in the situation and the circumstances that exist?

What mechanisms or supports are needed to ensure that multiple sectors are involved in decision-making?

Population Health Checklist – Oct 3, 2002

APPENDIX FOUR

Detailed Definitions of Proposed Primary Health Care Services

The examples of activities and services within the definition of each service category are not intended to be complete. They are intended to give a solid understanding of the type of activities that are involved in that service. Some services and activities are included in more than one category. This shows that none of these categories of services is necessarily separate and distinct from another. It is recognized that the definitions will need to be further refined as planning moves to implementation.

1. **Basic Emergency Services** - involves emergency services that may safely be delivered in the community setting. Also known as pre-hospital emergency health services, it generally includes basic first-aid, assessment (including triage) and diagnostics, some therapeutics, administration of some medications, and transport and transfer to other appropriate services when required. (adapted from Wanke et al, 1995, and Medical Policy, Protocol and Procedure Manual, Emergency Health Services, Nova Scotia Department of Health, 2001).
2. **Communicable Disease Prevention and Control** - programs and services provided under the Nova Scotia Health Act, in order to identify, reduce, and eliminate risks to human health. Programs address non-vaccine preventable diseases, vaccine preventable diseases, outbreak control, infection control in Long Term Care Facilities and community settings, and emergency preparedness. Surveillance is an integral part of all communicable disease prevention and control programs. (Public Health, Nova Scotia Department of Health, 2002).
3. **Community Mental Health Services** - includes activities that address the prevention, identification, treatment, and management of mental health problems for children, youth, adults, seniors, and the homeless. This includes a range of psychological supports and mental health treatments, but is not limited to such things as early identification and intervention of mental health problems, the promotion of mental health, and the prevention of mental illness, the maintenance of independence for those with serious and persistent mental illnesses, the management of anxiety and the treatment of mood disorders, the development of competencies and lifestyle in support of mental health and well-being, the treatment of comorbidity (mental health problems with addictions, medical illnesses, dementias, and developmental disorders), support for caregivers (family, parents, partners) in the management of mental illness, the management of emotional distress, mental disability, and social dysfunction; and family counseling services. (Nova Scotia Department of Health, Mental Health Services)
4. **Community Supports** are those activities that enable individuals, families, and communities to have access to and participate in actions to promote their health, and activities that assist them in identifying and/or increasing their capacity to do so. These types of services are most often planned, arranged for, or delivered by not-for-profit community-based organizations and volunteers that fall outside of the public system. They address the various determinants of health and include things such as support groups, self-help groups, transition houses, breakfast programs, career counseling and employment support, community outreach, recreation programs, access to the internet, childcare, access to banking machines, language/cultural interpreters, spiritual resources, adult and youth education and support programs, transportation programs, literacy programs, community access centers, libraries, meals on wheels, multi-cultural groups, etc. (adapted from Provincial Health Standards,1997, and work of the Task Team, 2002)

5. **Continuing Care** (Home Care, Long Term Care, Small Options Homes, Palliative Care, etc.) – services include nursing homes, homes for the aged, residential care facilities, small options homes, community residences, adult protection, home oxygen, and acute and long-term home care services. Services fall into two categories: assessment and coordination services (intake, assessment, service planning, resources authorization and ongoing case management) and care services (nursing care, personal care, home support, rehabilitation, respiratory therapy services, palliative care, and respite. (Adapted from the Department of Health's 2002/03 Business Plan)

6. **Dental Health Services** - includes diagnostic, preventive, and restorative services related to the achievement and maintenance of oral health. It may include activities such as selected preventive and oral surgical procedures, caries prevention services, restoration of cavities, fluoride mouth rinse programs for high-risk populations and screening programs for infants and children. (adapted from Children's Oral Health Program, 2002)

7. **Environmental Health Services** - includes monitoring, analyzing, reporting, and taking action to reduce illness, maintain and improve physical and social environments, and enhance behaviors to reduce morbidity and premature mortality, and improve health. This involve such things as health protection, preventing the occurrence or spread of infectious/communicable diseases or agents, outbreak management, coordination of disease control activities and responding to community concerns about the potential health effects of environmental changes. Some of these services and activities require the involvement of the department's partners in the Departments of Environment, Fisheries, and Agriculture. Examples of environmental health activities include, but is not limited to municipal and private water quality sampling and monitoring, monitoring of air quality in public places, environmental contaminant monitoring and education, emergency response preparedness, and disposal of bio-hazardous waster (sharps, etc.) (adapted from position description, Regional Medical Officer of Health, conversation with Provincial Medical Officer of Health, and discussions of Task Team, 2001)

8. **Health Promotion** (including community development) – is the process of enabling people to increase control over and to improve their health. Effective health promotion strengthens the skills and capabilities of individuals to take action, and the capacity of groups or communities to act collectively to exert control over the determinants of health. It involves activities within each of the following strategies
   - building healthy public policy (i.e. mandatory physical education)
   - creating supportive environments
   - strengthening community action
   - developing personal skills (such as leadership, self esteem development, cultural enrichment and heritage support, role modeling)
   - reorienting health services

   Examples of health promotion strategies include, but are not limited to, health education, mass communications/social marketing, legislation/healthy public policy, income support (fiscal measures), community organizational change, community development, and local community action/advocacy. (Sources: Ottawa Charter and "The Evidence of Health Promotion Effectiveness")

9. **Healthy Child Development** - Services that support healthy child development should be based on meeting the basic needs of children (i.e., safety; adequate nutrition; attachment to parents and/or caregivers; stimulation;

language, emotional, social, motor, and communication skills), parents and families. Activities designed to achieve desired healthy child development outcomes can be organized into four key components:

- parenting and family supports
- pregnancy, birth and infancy
- early childhood care and learning
- community supports

Healthy Child Development services use a range of strategies including education, care and intervention to policy and economic support. Specific examples include parent support and education, prenatal and postnatal supports, play-based problem solving learning for infants and young children, toy and resource libraries, nutrition/food programs, universal medical service, universal public health services, specialized services for young children and families, maternity/paternity leave, child care supplements, tax credits, home visiting programs for new parents, and well-baby clinics

(adapted from McCain & Mustard, 1999, and the First Ministers Agreement on Early Childhood Development, 2000).

10. **Nutrition services** – Nutrition services work in partnership with clients and other health and social services to enable communities, families, and individuals to achieve optimal health outcomes. Nutrition services can be delivered along the continuum of primary health care including health enhancement, risk avoidance, risk reduction, early intervention, intervention and rehabilitation, and treatment (acute, palliative, and chronic). Services are provided to all age groups with priority placed on nutritionally vulnerable groups such as the very young and the elderly, those whose food practices are developing such as children and youth, and those without adequate resources to support healthy eating. Within the context of a population health approach, nutrition services include many strategies aimed at promoting healthy eating in order to prevent and manage chronic disease and to foster healthy child development. Examples of nutrition services integral to primary health care include

- Providing nutritional care to individuals and groups based on assessing nutritional status, screening for nutrition-related risk factors, implementing and evaluating nutrition care plans, counseling and supporting clients and families. (i.e., weight control and diabetes management and prevention in adult population groups; pregnant women, infants and preschoolers; elderly persons in long term care facilities)
- Creating supportive environments (i.e., working with communities to establish community kitchens, and community gardens, and school food services supporting healthy eating)
- Strengthening community action through education and information (i.e., workshops and media presentations on healthy eating in prevention of chronic disease and promoting healthy body weight throughout life)
- Developing personal skills through education and training tailored to specific population groups (i.e., providing supermarket tours on label reading and food selection, skill training in food preparation for adults to support independent living in group homes)
- Reorienting health services (i.e., facilitating networks and referrals with other primary health care providers; educating providers on nutrition and health issues)
- Advocating for healthy public policy and supporting its effective implementation (i.e., promoting school policies that support healthy eating, physical activity and healthy weights, food allowance rates adequate to support healthy eating for people on social assistance)

(British Columbia Guidelines to Support Best Practice in Community Nutrition, and Dietitians of Canada, "The Role of the Registered Dietitian in Primary Health Care: A National Perspective")

11. **Primary Maternity Care** - Primary Maternity Care is part of comprehensive primary care for and within a community. It is based on the philosophy that pregnancy and childbirth are natural processes that require a focus on health, and should be individualized. Within the context of primary health care, it is an important way of working toward developing healthy communities. The continuum of primary maternity care includes pre- and post-conception, pre-natal and intra- and post-partum phases and includes such services as pre- and post-conception counseling (contraception, healthy lifestyle, risk reduction), prenatal education and care (birth planning and screening), supportive and skilled care during and labor and birth and supportive and skilled care during the transition to self-care, infant care, and family integration. (Task Team on Existing and New Primary Health Care Providers, 2002)

    Examples of primary maternity care supports include the following: early and ongoing assessment of the physical/psychosocial health of the mother, fetus and infant; screening, risk-assessment and referral; medical and psychosocial support and referral; health education and promotion; and promotion, protection, and support for breastfeeding. Screening and risk-assessment and appropriate referral are commonly conducted to identify the following risks: genetic disorders, blood borne pathogens, gestational diabetes, malnutrition, smoking, alcohol and drug use/abuse, postpartum depression, violence, and potential developmental delay. (Public Health, NS Department of Health)

12. **Prevention & Treatment of Common Diseases and Injuries** – Prevention consists of an intervention that has been shown to significantly reduce the likelihood that a disease or a disorder will affect an individual/population, or an intervention that disrupts or slows the progression of that disease. Prevention activities include immunization, disease outbreak control, prevention of different types of injuries (intentional and unintentional) in different populations (children and youth, workers, older Canadians), maternal and child health care, prevention of sexually transmitted infections, etc. Specific examples of prevention activities include healthy eating and physical activity social marketing campaigns, cervical and breast screening, seat belt legislation, and childhood immunization.

    Treatment of common diseases and injuries involves activities designed to address identified health issues or conditions across the life spectrum (i.e., infants, children and youth, teens, adults, and seniors. These represent a range of assessment and treatment services to address acute or chronic conditions, and referral services to specialized institutions or providers. (adapted from Wanke et al., 1999). Examples include primary medical care and disease management.

13. **Rehabilitation Services** - includes services designed to improve or maintain the biological, physiological, spiritual, psychological and/or sociological ability of individuals to function as independently as possible and to re-integrate into the community. Types of rehabilitation activities include assessment, treatment, education, counseling, and environmental adaptation. Examples of rehabilitation services include physical therapy, occupational therapy, speech-language pathology, audiology, respiratory therapy, recreational therapy, addictions, supportive employment, adaptive housing, and assisted education. (adapted from definition in Wanke, et al., 1995 and Task Team discussions, 2001)

14. **Sexual Health/Family Planning Services** - involves family planning services and services that aim to promote, protect, and maintain sexual health (i.e., knowledge of self, opportunities for healthy sexual development and sexual experience, capacity for intimacy,

ability to share relationships and comfort with different expressions of sexuality including love, joy, caring, sensuality, or celibacy) for individuals across the life span. Many of these services are in the form of information, education, and support. They include such things as condom distribution, emergency contraception program, menopause education, teen health services (i.e., sexual health education in schools, healthy decision making), sexual assault emergency response system/teams, treatment of Sexually Transmitted Diseases, adoption counseling, family planning counseling. (adapted from "A Report from Consultations on a Framework for Sexual and Reproductive Health," Health Canada, 1999, and Task Team discussions, 2001)

15. **Other publicly funded services** – These are services that are delivered by other public sectors such as Community Services, Education, Justice, and Environment and Labor. Examples may include occupational health and safety programs and housing, income assistance, and education programs.

APPENDIX FIVE

Definition of Primary Maternity Care

Primary Maternity Care is part of comprehensive primary care for and within a community (Attenborough, 2002). It is based on the philosophy that pregnancy and childbirth are natural processes that require a focus on health and should be individualized. Within the context of primary health care, it is an important way of working toward developing healthy communities.

The continuum of primary maternity care includes pre- and post-conception, pre-natal and intra- and post-partum phases and includes such services as pre- and post-conception counseling (contraception, healthy lifestyle, risk reduction), prenatal education and care (birth planning and screening), supportive and skilled care during and labor and birth and supportive and skilled care during the transition to self-care, infant care and family integration. A variety of providers may be involved in delivering support and primary care throughout this continuum, including for example family practice nurses, hospital and public health nurses, nurse practitioners, family physicians, midwives, doulas, nutritionists, pharmacists, health educators, lactation consultants, social workers, obstetricians , and, in some cases, homecare providers.

APPENDIX SIX

Remaining Recommendations of the Task Team on Existing and New Primary Health Care Providers:

"Teams"

1. The core team of providers is the means of access to primary health care services.
2. Each provider on the core team provides a point of access to the team.
3. In response to the needs of the population it serves, the core team provides the range of services that is within each provider's scope of practice.
4. Team members are responsible for assessing client strengths and needs, and either supporting the client in meeting that need or facilitating/ensuring access to the right provider or community resource. The "right" provider is determined based on a variety of factors such as maximizing scope of practice, short and long term outcomes, economic efficiency, continuity of provider to the client, and other contextual factors including the physical setting and environment.
5. Similarly, a mechanism or process exists to facilitate referral to the team by any person in the community (either within or outside of health) who provides care or services that affect the determinants of health.

6. The time it takes for a team member to assess and assist a client in obtaining the appropriate resource is funded.
7. The preferred set-up for a core team is shared/common physical location, or at least location within the same community. However, not every community will have all possible members of the team. In these instances, communities will need to work together to create core and extended collaborative teams.
8. Using a variety of communications mechanisms (such as web site and brochures), the core team informs the public of who they are, the services they provide, the hours of access, and how each can be accessed.
9. Using a variety of communication mechanisms, the District Health Authority informs the public (including providers) of the core and extended team members, services and how they can be accessed, and other resources (providers, levels of care, other related community resources) that are available within their district.
10. The accountabilities and expectations of each team member are clearly outlined in an accountability framework that defines each provider's role, responsibilities and accountabilities, how and in what situations providers would work together, principles for communication, and funding/payment. The accountability framework would also identify mechanisms for ensuring that each provider was fulfilling his or her responsibilities. (The Collaborative Practice Agreement that is currently required between family physicians and nurse practitioners in Nova is an example of a formal accountability framework.)
11. Relationships among core and between core and extended members are based on pre-established and/or negotiated principles of collaborative practice.
12. There is a dedicated team leader within the core and extended team. This leadership function is funded.
13. The workplace (either real or virtual) is one that supports and dedicates time to communication and relationship building among team members.
14. There is an established activity or mechanism within the team that supports the ongoing development of the team, as well as the individual professional development of team members.
15. The structure of the organizations within which these teams work provides administrative support and leadership that values quality of work-life and is committed to creating and supporting an environment in which the core and extended team can thrive.
16. Provider payment models enable collaboration among members of the primary health care team.
17. Interdisciplinary collaborative teams must work in a planned and coordinated fashion with Community Health Boards, District Health Authorities, other government services, not-for-profit and non-government community organizations, and the private sector.
18. District Health Authorities must develop and ensure linkages between primary health care organizations, Community Health Boards, other District Health Authorities, government departments and agencies, not-for-profit and non-government community organizations, and the private sector within their districts.
19. The Department of Health must work together in a planned and coordinated fashion with other government departments and agencies, District Health Authorities, provincial not-for-profit and non-government community organizations, and the private sector to support the coordination and delivery of primary health care services.

20. The task team supports the concepts of using methods of provider payment that 1) encourage and/or require collaboration among providers, and 2) enable and/or support the delivery of "upstream" prevention and promotion activities. It is expected that the Task Team on Funding and Physician Payment will further address these issues in their deliberations and recommendations.
21. District Health Authorities must support change management activities and the funding to participate in them.